

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

FOR
1- STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 2 1 5 6 3

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Miomie Huffer Ables			2a. DATE OF DEATH MONTH DAY YEAR 08 07 81			2b. HOUR 5:25 P.M.				
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 9 14 03		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS 77		
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		9. CITIZEN OF WHAT COUNTRY? USA		10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		11. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD			12. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SALESLADY	
13. CITY OR TOWN OF DEATH GAITHERSBURG		14. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) WILSON HEALTH CARE CENTER				15. KIND OF BUSINESS OR INDUSTRY Dept. Store		16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		
17. COUNTY Montgomery		18. CITY OR TOWN Gaithersburg		19. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20. STREET ADDRESS 201 Russell Avenue			21. FATHER'S NAME FIRST MIDDLE LAST HARRY BLAZE HUFFER	
22. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST PEARL HAYES BISER		23. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		24. SOCIAL SECURITY NO. 214-10-2680		25. INFORMANT Margaret B. Ringer			26. ADDRESS 208 Linden Avenue Frederick, Maryland	
27. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebrovascular Thrombosis 4292 DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic cardiovascular disease 15 years DUE TO, OR AS A CONSEQUENCE OF (c) disease APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): Essential hypertension										
28. DATE OF OPERATION		29. CONDITION FOR WHICH OPERATION WAS PERFORMED				30. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		31. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
32. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		33. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. NONE 19		34. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)						
35. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		36. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		37. LOCATION STREET CITY OR TOWN COUNTY STATE						
38. I certify that (a) this person attended the deceased from March 4 19 1963 to Aug 7 19 81 , that (b) (we) last saw the deceased alive on Aug 6 19 81 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (b) (we) (did) (did not) view the body after death.										
39. SIGNATURE Stephen C. Cromwell MD				40. DEGREE MD		41. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		42. DATE SIGNED 8/7/81		
43. PHYSICIAN'S NAME (TYPE OR PRINT) Stephen C. Cromwell, MD				44. ADDRESS 615 W. Montgomery Ave Rockville, Md						
45. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		46. DATE 8/12/81		47. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		48. LOCATION CITY OR TOWN COUNTY STATE Frederick Frederick Md.		49. FUNERAL DIRECTOR NAME Tyson Wheeler Funeral Home, Inc.		
50. ADDRESS 1331 Rockville Pike Rockville, Maryland				51. DATE REC'D. BY REGISTRAR AUG 14 1981		52. REGISTRAR'S SIGNATURE James J. Hartman				

2011-2012

Burial
Tyson, Fred, General Home, Ind.
1331 Rockville Pike, Rockville, Maryland

Ms. Oliver Cemetery, Frederick, Md.

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Tyson, Fred, General Home, Ind.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8	1	2	1	5	6	4
1- FOR STATE REGISTRAR										REG. NO.						
1. DECEASED NAME (TYPE OR PRINT) Patricia Ann ADAMS										2a. DATE OF DEATH MONTH DAY YEAR August 24 1981				2b. HOUR 3:45AM		
3 SEX Female			4. RACE Caucasian			5. DATE OF BIRTH MONTH DAY YEAR Dec. 24 1935			6. AGE (IN YEARS LAST BIRTHDAY) 45			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. YRS.		IF UNDER 24 HRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Massachusetts			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.							
10. CITY OR TOWN OF DEATH Bethesda			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) National Naval Medical Center							12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Program Analyst				12b. KIND OF BUSINESS OR INDUSTRY State Dept.		
13a. STATE Virginia			13b. COUNTY Fairfax			13c. CITY OR TOWN Springfield			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 5506 Atlee Place					
14. FATHER'S NAME FIRST MIDDLE LAST Patrick Leonard					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Katherine McLaughlin											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No					16b. SOCIAL SECURITY NO. 029 28 8009			17. INFORMANT ADDRESS George Adams 5405 Denison Pl., Sprf Va.								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 1729 Malignant melanoma IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____																
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE										
22a. I certify that (1) (this hospital) attended the deceased from August 12 , 19 81 , to August 24 , 19 81 , that (1) (we) lost see the deceased above, (1) (we) did not view the body after death. above, (1) (we) did not view the body after death.																
22b. SIGNATURE M. Gurney CT MC								DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED Aug. 24, 1981						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) M. GURNEY, M.D.								22e. ADDRESS National Naval Medical Center, Bethesda, Md.								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE Aug 26 81		23c. NAME OF CEMETERY OR CREMATORY Arlington National				23d. LOCATION CITY OR TOWN COUNTY STATE Arlington Arlington Va.						
24. FUNERAL DIRECTOR NAME DeMaine Funeral Home ADDRESS Alexandria, Va.								25a. DATE REC'D. BY REGISTRAR AUG 31 1981		25b. REGISTRAR'S SIGNATURE [Signature]						

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR 1 - STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR	
PABLO			O	ALIGNAY	8		8	81	4:10 AM		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
MALE		Filipino		2 10 1910		71		MONTHS		DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
PHILIPPINES		U.S.A.				Montgomery MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Silver Spring		Holy Cross Hospital				Machinist					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
13a. STATE				Washington		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		12 Chesapeake Street, SW			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
Claro		Alignay		Balbina		Son		8707 Nightingale		Seabrook, Md.	
No				217 70 8556		Rogelio L. Alignay					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> 4100 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Hypertensive arteriosclerotic Heart Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Unknown</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 hours	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>None</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (the hospital) attended the deceased from <u>August 7</u> 19 <u>81</u> to <u>August 8</u> 19 <u>81</u> , that (I) (we) last saw the deceased alive on <u>August 8</u> 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.											
22b. SIGNATURE		DEGREE				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED			
Aaron H. Traum		MD						August 8 1981			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS									
AARON H. TRAUM MD		5915 Georgia Ave Silver Spring Md 20910									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
Burial		Aug 11-81		Washington National		Suitland PG Md					
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Robert E. Wilhelm Enrl Home		Suitland Md		AUG 11 1981							



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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of cause.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
1- FOR STATE REGISTRAR									
CERTIFICATE OF DEATH									
REG. NO.									
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH				
FIRST MIDDLE LAST Rena Altman					MONTH DAY YEAR HOUR 8 14 81 8:40 AM				
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR	
Female		White		JULY 20, 1895		86		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Wash. D.C.		USA				Montgomery MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)							
Takoma Park		Washington Adventist Hospital Housewife							
12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		12b. KIND OF BUSINESS OR INDUSTRY							
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?			
Md.		Mont.		S.S.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		13e. STREET ADDRESS					
FIRST MIDDLE LAST John H. Wood		FIRST MIDDLE LAST Eva Padgett		10009 Quincy Court					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
None		WA532934		705 Venice Drive John Altman (Son) S.S. Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART I. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <u>Respiratory Failure</u>									
4148 DUE TO, OR AS A CONSEQUENCE OF									
(b) <u>Congestive Heart Failure</u>									
DUE TO, OR AS A CONSEQUENCE OF									
(c) <u>Myocardial Ischemia</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
<u>Generalized Arteriosclerosis - Cerebral Infarct</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
		HOUR A.M. MONTH DAY YEAR P.M. 19							
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION					
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>MAY</u> 19 <u>73</u> , to <u>Aug 14</u> 19 <u>81</u> , that (I) (we) lost									
saw the deceased alive on <u>Aug 13</u> 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated									
22b. SIGNATURE									
DEGREE <u>M.D.</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>									
22c. DATE SIGNED <u>8-14-81</u>									
22d. PHYSICIAN'S NAME (TYPE OR PRINT)									
<u>ROBERT B. IREY</u>									
22e. ADDRESS									
<u>11161 New Hampshire Ave, Silver Spring</u>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION			
Burial		8/17/81		Cedar Hill Cemetery		CITY OR TOWN COUNTY STATE Suitland PG Maryland			
24. FUNERAL DIRECTOR									
NAME ADDRESS Hines/Rimaldi F.H. 11800 N.H. Ave. S.S.									
25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE									
AUG 18 1981									



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1. FOR STATE REGISTRAR										REG. NO.									
1. DECEASED NAME (TYPE OR PRINT) HILMER H. Anderson Jr.										2a. DATE OF DEATH MONTH 8 DAY 9 YEAR 81 2b. HOUR 2:05 P.									
3 SEX M.			4 RACE Caucasian			5. DATE OF BIRTH MONTH Aug DAY 29 YEAR 1922			6 AGE (IN YEARS LAST BIRTHDAY) 59 YRS.			IF UNDER 1 YEAR MONTHS DAYS 		IF UNDER 24 HRS. HOURS MIN. 					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Mass			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD										
10. CITY OR TOWN OF DEATH Bethesda			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital																
12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Monty			13c. CITY OR TOWN Wheaton			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 12004 Colin Rd							
14. FATHER'S NAME FIRST Hilmer H. MIDDLE Anderson Sr LAST 										15. MOTHER'S MAIDEN NAME FIRST Dorothy MIDDLE unk LAST Martin									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes										16b. SOCIAL SECURITY NO. WW 11			17. INFORMANT Virginia M. Hilmer (Wife) ADDRESS see 13 a.						
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 1629 Respiratory Failure, Pericardial										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 1/2 hrs.									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) Renal Failure, Tamponade										7 days									
DUE TO, OR AS A CONSEQUENCE OF (c) Carcinoma of the Lung										2 months									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Cardiac Arrhythmia																			
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)					21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19					21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>					21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)					21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from 7/27 19 81 , to 8/9 19 81 , that (I) (we) last saw the deceased alive on 8/9/81 19 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (I) (did) (did not) view the body after death.																			
22b. SIGNATURE John A. Galotto MD DEGREE MD										22c. DATE SIGNED 8/9/81									
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John A. Galotto MD										22e. ADDRESS 5225 Pooks Hill Rd Bethesda Md 20854									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation					23b. DATE Aug 10, 1981			23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory			23d. LOCATION CITY OR TOWN COUNTY STATE Pr. George Md								
24. FUNERAL DIRECTOR W. W. Chambers Co, Inc ADDRESS 8655 Georgia Ave, S. S.										25a. DATE REC'D. BY REGISTRAR AUG 13 1981 REGISTRAR'S SIGNATURE [Signature]									

2002 Cotton

W/101110

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

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FOR
STATE
REGISTRAR

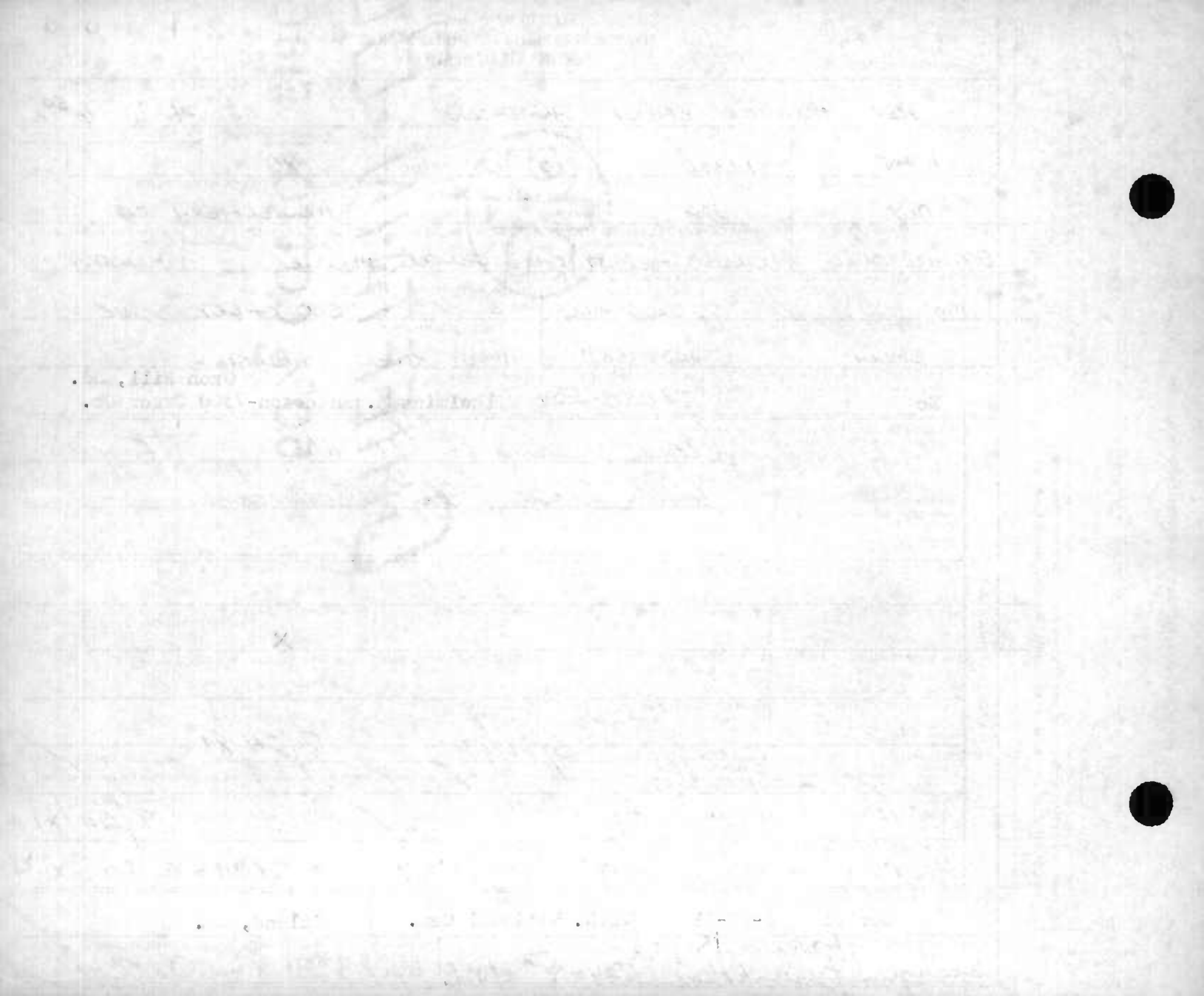
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) REV. HOWARD EMORY ANDERSON			2a. DATE OF DEATH MONTH 08 DAY 24 YEAR 81			2b. HOUR 6³⁰ PM	
3. SEX MALE		4. RACE NEGRO		5. DATE OF BIRTH MONTH 10 DAY 13 YEAR 1900		6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY CO. MD.	
10. CITY OR TOWN OF DEATH GAITHERSBURG		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) WILSON HEALTH CARE CENTER				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) MINISTER	
13a. STATE MD		13b. CITY OR TOWN OXON HILL		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS 7500 GREER DRIVE	
14. FATHER'S NAME FIRST EMORY MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MARY ELLEN MIDDLE HAWKINS LAST		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			
16b. SOCIAL SECURITY NO. 220-03-5354		17. INFORMANT Wilhelmina M. Anderson-7500 Greer Dr.					
18. CAUSE OF DEATH (Enter only one cause per line or (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adenocarcinoma of Prostate 1850 DUE TO, OR AS A CONSEQUENCE OF (b) with widespread metastases DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 YRS.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 8/20/81 to 8/24/81 , that (I) (we) lost saw the deceased alive on 8/20/81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Henry C. Scruggs MD		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8/24/81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Henry C. Scruggs MD		22e. ADDRESS 5413 Cedar Lane Bethesda Md 20014					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8-29-81		23c. NAME OF CEMETERY OR CREMATORY Wash. National Cem.		23d. LOCATION CITY OR TOWN Suitland, Md. COUNTY STATE	
24. FUNERAL DIRECTOR NAME Harold Kyles ADDRESS Spangler Funeral Home 524-9th St NE				25a. DATE REC'D. BY REGISTRAR AUG 28 1981 REGISTRAR'S SIGNATURE James J. Martin			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

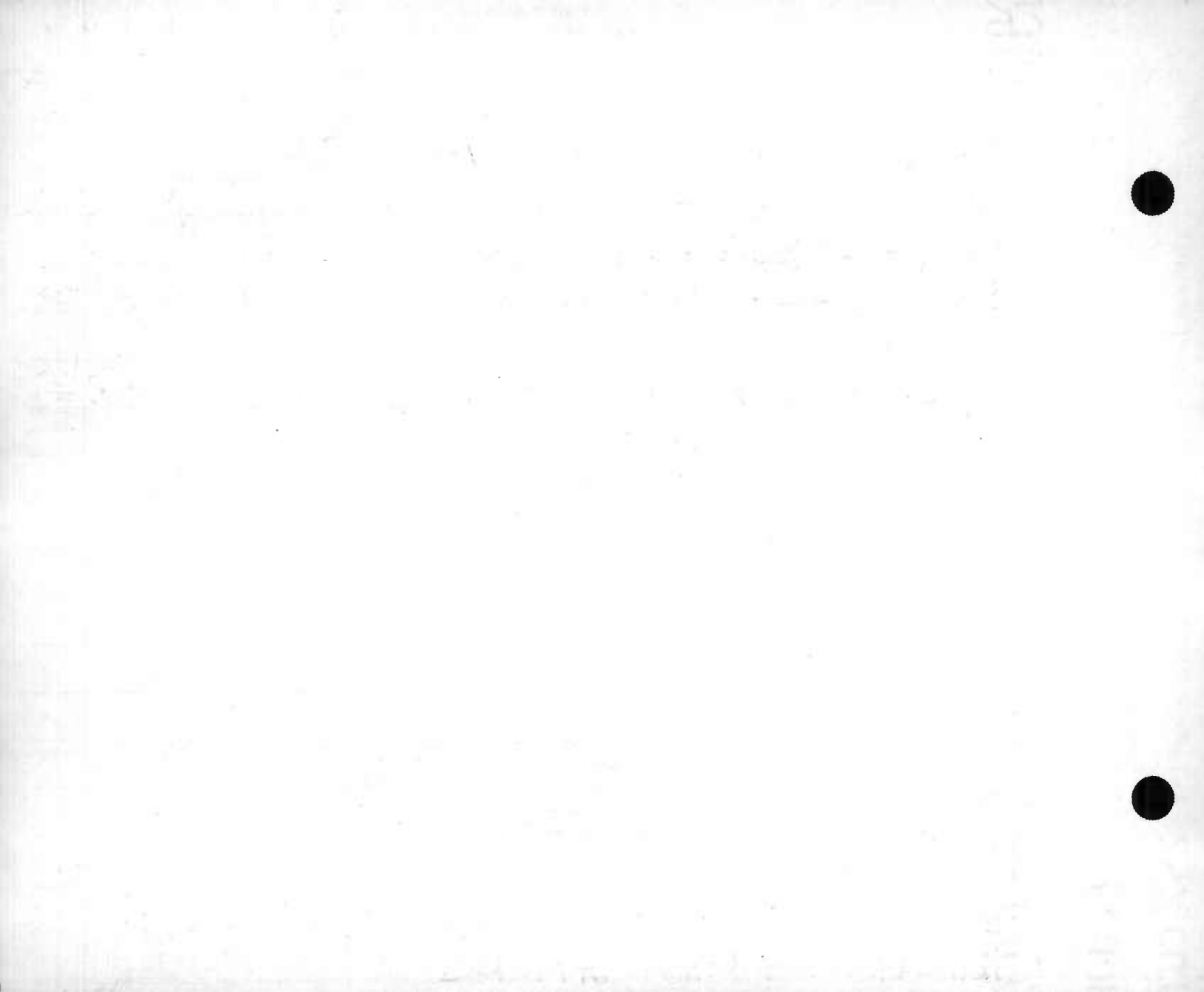
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		8 1 2 1 5 6 9	
1. DECEASED NAME (TYPE OR PRINT) REBE 11		2a. DATE OF DEATH MONTH DAY YEAR 8 7 81	
3. SEX Male		4. RACE Negro	
5. DATE OF BIRTH MONTH DAY YEAR 2-11-1889		6. AGE (IN YEARS LAST BIRTHDAY) 92	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Alabama		7b. CITIZEN OF WHAT COUNTRY? U.S.A.	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Silver Spring, Maryland	
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION Belle Pre Nursing Home	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY None	
13a. USUAL RESIDENCE (IF HUSBAND OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) D.C.		13b. CITY OR TOWN Wash D.C.	
14. FATHER'S NAME FIRST MIDDLE LAST Unknown		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. 7-31-1918	
17. INFORMANT Philina Thompson		ADDRESS 35-T-St NE Wash DC	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (b) arteriosclerotic heart disease DUE TO, OR AS A CONSEQUENCE OF (c) 4100 Conditions, if any, which gave rise to immediate cause (d), stating the underlying cause lost.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 YRS	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21a. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. LOCATION STREET CITY OR TOWN COUNTY STATE	
22. I certify that (I) (this hospital) attended the deceased from 7/15 , 19 81 , to 8/7 , 19 81 , that (I) (we) last saw the deceased alive on 8/6 , 19 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22a. SIGNATURE R.D. Benack		22b. DEGREE MD	
22c. PHYSICIAN'S NAME (TYPE OR PRINT) R.T. Benack MD		22d. ADDRESS 4115 Colie Dr. Wheaton, Md.	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8-11-81	
23c. NAME OF CEMETERY OR CREMATORY Richmond Nat Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Richmond, Virginia	
24. FUNERAL DIRECTOR NAME Samuel F. Woodford & Sons		25. DATE RECEIVED BY REGISTRAR AUG 13 1981	
26. REGISTRAR'S SIGNATURE James J. Martin			



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Released by the State

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
1. FOR STATE REGISTRAR					8 1 2 1 5 7 0				
CERTIFICATE OF DEATH					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) Robert Ash					2a. DATE OF DEATH MONTH DAY YEAR 8.10.81.			2b. HOUR 11:45P_M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Oct. 1 1894		6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Lawyer		12b. KIND OF BUSINESS OR INDUSTRY Law Firm	
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Bethesda		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 6817 Bradley Blvd.	
14. FATHER'S NAME FIRST MIDDLE LAST John R. Ash				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lucretia E. Kingston					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No				16b. SOCIAL SECURITY NO. 216-38-5870		17. INFORMANT ADDRESS Frances Ash. Wife. Same as item 13.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 43229 IMMEDIATE CAUSE (a) Respiratory arrest DUE TO, OR AS A CONSEQUENCE OF (b) Pulmonary Hemorrhage DUE TO, OR AS A CONSEQUENCE OF (c) Shock Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 hours
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (his) hospital attended the deceased from 8-10 , 19 81 , to 8-10 , 19 81 , that (I) (we) last saw the deceased alive on 8-10 , 19 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>[Signature]</i>					DEGREE			22c. DATE SIGNED 8/10/81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Joseph Gawler's Sons Inc.					22e. ADDRESS 5130 Wisc. Ave., N.W. Wash., D.C.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 8/14/1981		23c. NAME OF CEMETERY OR CREMATORY Grove Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Dallas Texas.		
24. FUNERAL DIRECTOR NAME Joseph Gawler's Sons Inc.					25a. DATE REC'D. BY REGISTRAR AUG 14 1981		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>		

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1- FOR
STATE
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) Marie A. Aumiller			2a DATE OF DEATH MONTH DAY YEAR August 13, 1981			2b HOUR 11:50 AM			
3 SEX Female		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR Aug. 17, 1924		6 AGE (IN YEARS LAST BIRTHDAY) 56 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) New Jersey		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10 CITY OR TOWN OF DEATH Olney		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery General Hospital				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b KIND OF BUSINESS OR INDUSTRY	
13a STATE Maryland		13b COUNTY Montgomery		13c CITY OR TOWN Gaithersburg		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS 983 Clopper Road	
14 FATHER'S NAME FIRST MIDDLE LAST Philip Lemmo				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Agnes Monaco					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO. 145-14-6107		17 INFORMANT ADDRESS Gary S. Aumiller, Item 13					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary Arrest 4100 DUE TO, OR AS A CONSEQUENCE OF (b) Acute Anterior Myocardial Infarct DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:10									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (I) (this hospital) attended the deceased from 8/13 , 19 81 , to 8/13 , 19 81 , that (I) (we) lost saw the deceased alive on 8/13 , 19 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE Daniel J. Goldberg				DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c DATE SIGNED 8/13/81	
22d PHYSICIAN'S NAME (TYPE OR PRINT) Daniel Goldberg				22e ADDRESS 10401 Old Georgetown Rd - Bethesda					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE Aug. 17, 1981		23c NAME OF CEMETERY OR CREMATORY Mt. Olivet		23d LOCATION CITY OR TOWN COUNTY STATE Frederick, Frederick, Md.			
24 FUNERAL DIRECTOR NAME Olin L. Molesworth, P.A., Damascus, Md.				25a DATE REC'D. BY REGISTRAR AUG 17 1981					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, and returned by the hospital or attending physician. **Cleared by Medical Examiner - Daniel Goldberg**

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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Figure 1. *Estimated* β and σ^2 for the β and σ^2 parameters.

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121

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE MEDICAL EXAMINER SHOULD EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME, AND PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR THE MEDICAL EXAMINER. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 21572	
1. DECEASED NAME (TYPE OR PRINT)		FIRST Walter		MIDDLE P.		LAST Baliles		2a. DATE KNOWN OF DEATH		MONTH DAY YEAR	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		7. DATE PRONOUNCED DEAD		MONTH DAY YEAR	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH		MONTH DAY YEAR	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?					
PART 1 DEATH WAS CAUSED BY:		21a. EXTERNAL CAUSE WAS		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED					
IMMEDIATE CAUSE (a)		UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		HOUR A.M. MONTH DAY YEAR		ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2					
CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a) STATING THE UNDERLYING CAUSE LAST.		21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION					
WHILE AT WORK		NOT WHILE AT WORK		Home		Grayson Ave. St. Leger					
22a. I certify that I took charge of the remains described above, held on death resulted from:		Autopsy		Inspection		Inquiry					
Natural causes		Accident		Suicide		Homicide		Undetermined manner			
ACTUAL SIGNATURE		TITLE (SPECIFY)		MEDICAL EXAMINER		DATE SIGNED					
EXAMINER'S NAME		1919 Seminary Road S.S.Md.									
23a. BURIAL, CREMATION, REMOVAL		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION					
Burial		08-25-81		Parklawn Cemetery		Rockville, Montgomery, Maryland					
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
Hines/Rinaldi Funeral Home, Inc.		AUG 26 1981		Rinaldi							
11800 New Hampshire Ave, Silver Spring, Md.											



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

BP

DHMH - 16 50M 1/81
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 2 1 5 7 3

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Ora L. BARKER			2a. DATE OF DEATH MONTH DAY YEAR August 25 1981			2b. HOUR 2:00P M		
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Aug. 24 1911		6. AGE (IN YEARS LAST BIRTHDAY) 70		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.		
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) National Naval Medical Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		
12b. KIND OF BUSINESS OR INDUSTRY Home								
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Virginia			13b. COUNTY Fairfax		13c. CITY OR TOWN Annandale		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Oscar Lee Mason			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ida Wilmer					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 228 36 7695		17. INFORMANT ADDRESS Frances E. Runzo See item 13				

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary arrest 4360 DUE TO, OR AS A CONSEQUENCE OF (b) Cerebral Vascular Accident Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
--	--	--	--

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (in this hospital) attended the deceased from July 27 , 19 81 , to August 25 , 19 81 , that (I/we) lost saw the deceased alive on August 25 , 19 81 , and that in (my/our) opinion death occurred on the date and hour and from the causes stated above, (I/we and) (do not) view the body after death.			
22b. SIGNATURE Gary Zaloga		22c. DATE SIGNED August 26 1981	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Gary ZALOGA, M.D.		22e. ADDRESS National Naval Medical Center Bethesda, Md.	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Aug 29, 1981		23c. NAME OF CEMETERY OR CREMATORY Forest Lawn Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Norfolk Va.	
24. FUNERAL DIRECTOR NAME ADDRESS Capitol Funeral Service Fairfax, Va.				25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE SEP 01 1981 Frances E. Runzo			

(M)

NOTICE

SEP 0 1881

AMERICAN

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 350-1234.



STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 1 2 1 5 7 4	
1. FOR STATE REGISTRAR				CERTIFICATE OF DEATH	
1. DECEASED NAME (TYPE OR PRINT)				7a. DATE OF DEATH	
Ehols F. BARNES				Aug 10, 81 2030	
3. SEX		4. RACE		5. DATE OF BIRTH	
Female		White		Sept. 18 1896	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		6. AGE (IN YEARS LAST BIRTHDAY)	
Maryland		U.S.A.		84 YRS.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		9. BALTIMORE CITY OR COUNTY OF DEATH	
Gaithersburg		Wilson Health Care Center		Montgomery MD.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		13a. STREET ADDRESS	
Saleslady-Housewife		Hutzlers		3706 Tudor Arms Ave.	
13a. STATE		13b. CITY OR TOWN		13c. INSIDE CITY LIMITS?	
Md.		Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES?	
Moses James Hudson		Madeline Watson		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
16b. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH	
218-22-3860		George Lee Barnes III		Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC ARRST</u> (b) <u>4140</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>ARTERIOSCLEROTIC HEART DIS</u> <u>ARTERIOSIS</u> <u>4140</u> <u>IMMEDIATE</u> <u>YEARS</u> <u>"</u>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED	
<input type="checkbox"/>		HOUR A.M. MONTH DAY YEAR		ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2	
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION	
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (i) (the hospital) attended the deceased from 8/6/81 to 8/10/81, that (i) (we) lost saw the deceased alive on 8/6/81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (ii) (we) (did) (did not) view the body after death.					
22b. SIGNATURE		22c. DEGREE		22d. DATE SIGNED	
[Signature]		M.D.		8/11/81	
22e. PHYSICIAN'S NAME (TYPE OR PRINT)		22f. ADDRESS		22g. DATE REC'D. BY REGISTRAR	
Ghos G. WARD		6116 ROBINWOOD, Bethesda, Md.		AUG 11 1981	
23a. BURIAL, CREMATION, REMOVAL		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Cremation		Aug. 12, '81		Lee's Crematory	
23d. LOCATION		23e. NAME OF CEMETERY OR CREMATORY		23f. LOCATION	
Washington, D.C.		Lee's Crematory		Washington, D.C.	
24. FUNERAL DIRECTOR		24b. ADDRESS		24c. DATE REC'D. BY REGISTRAR	
Gartner Sandison F. H.		316 E. Diamond Ave., Gaithersburg, Md. 20760		AUG 11 1981	

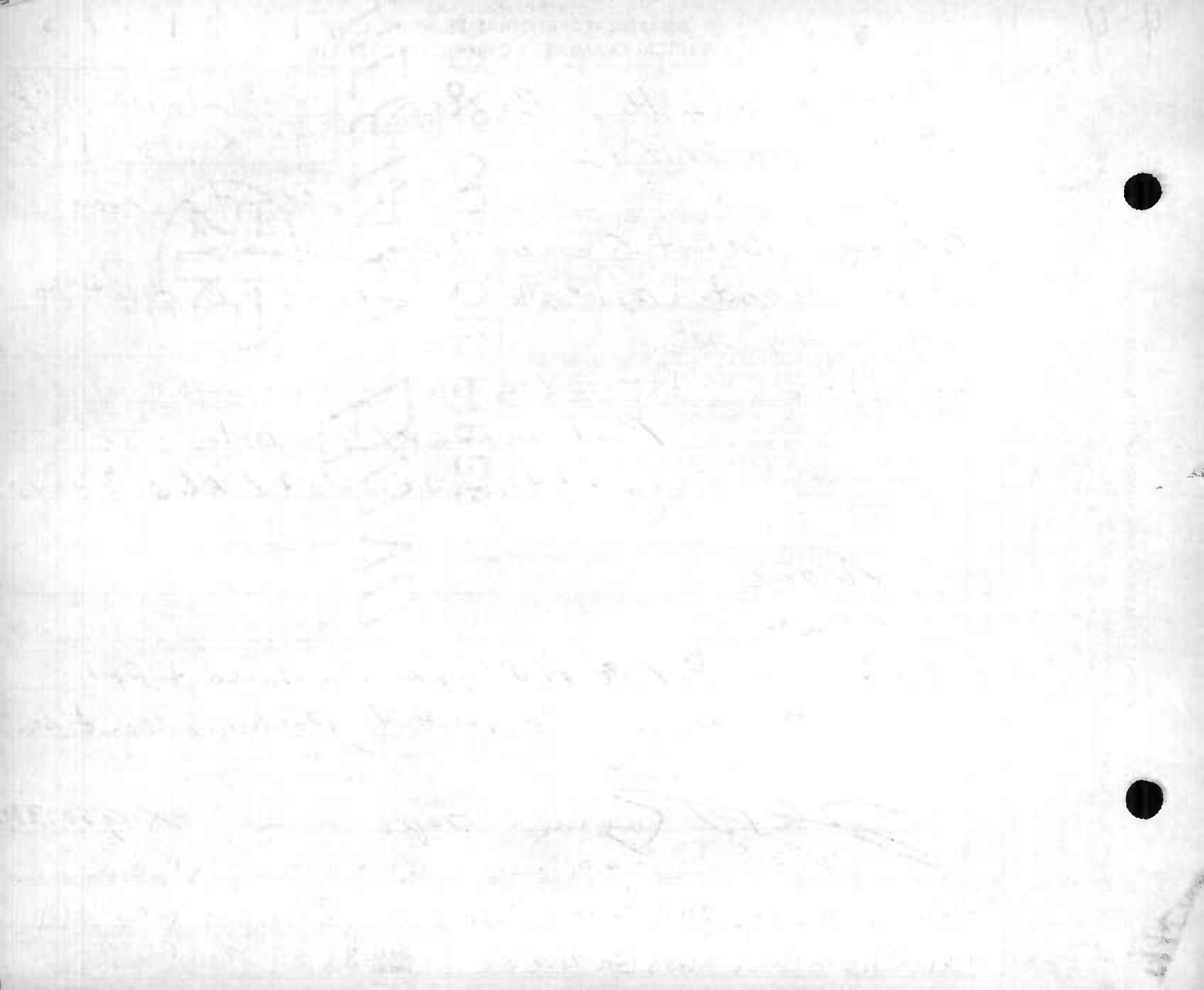


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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH - 17
(VRA 15 ME (5))
15M2/80

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 21575	
1. DECEASED NAME (TYPE OR PRINT) Virginia H. Barton										2a. DATE KNOWN OF DEATH Aug 22 1981	
3. SEX F	4. RACE W	5. DATE OF BIRTH Nov 24 1862	6. AGE (IN YEARS) 62 YRS.	7. IF UNDER 1 YR. MONTHS DAYS	7. IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD Aug 22 1981		2d. DATE KNOWN OF DEATH Aug 22 1981			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) D.C.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD					
10. CITY OR TOWN OF DEATH Olney		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Mont. General Hosp				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Md		13b. COUNTY Mont.		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 13409 Berblett St			
14. FATHER'S NAME CLARENCE HEYWARD				15. MOTHER'S MAIDEN NAME BESS Austin							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 577-22-842		17. INFORMANT ADDRESS GLENN BARTON 6215 Brooklet Dr							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 8850 Pulmonary Embolism Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) Fracture of tibia & fibula + L. Rib DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF (c) 3 days										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) None											
19a. DATE OF OPERATION None				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR 8:15 MIN PM MONTH 8 DAY 19 YEAR 81		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Slipped in mud + fell							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Home		21f. LOCATION STREET Berblett St. CITY OR TOWN Rockville COUNTY Mont. STATE Md							
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion	
ACTUAL SIGNATURE John S. Rogers				TITLE (SPECIFY) M.D. Dep.				DATE SIGNED Aug 22 1981			
EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers				ADDRESS 1919 Seminary Rd. S.S.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE Aug 27 1981		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION CITY OR TOWN Suitland COUNTY P.G. STATE Md					
24. FUNERAL DIRECTOR NAME W.H. Chambers ADDRESS 8645 Ga Ave S.S.				25a. DATE REC'D BY REGISTRAR AUG 31 1981		25b. REGISTRAR'S SIGNATURE [Signature]					

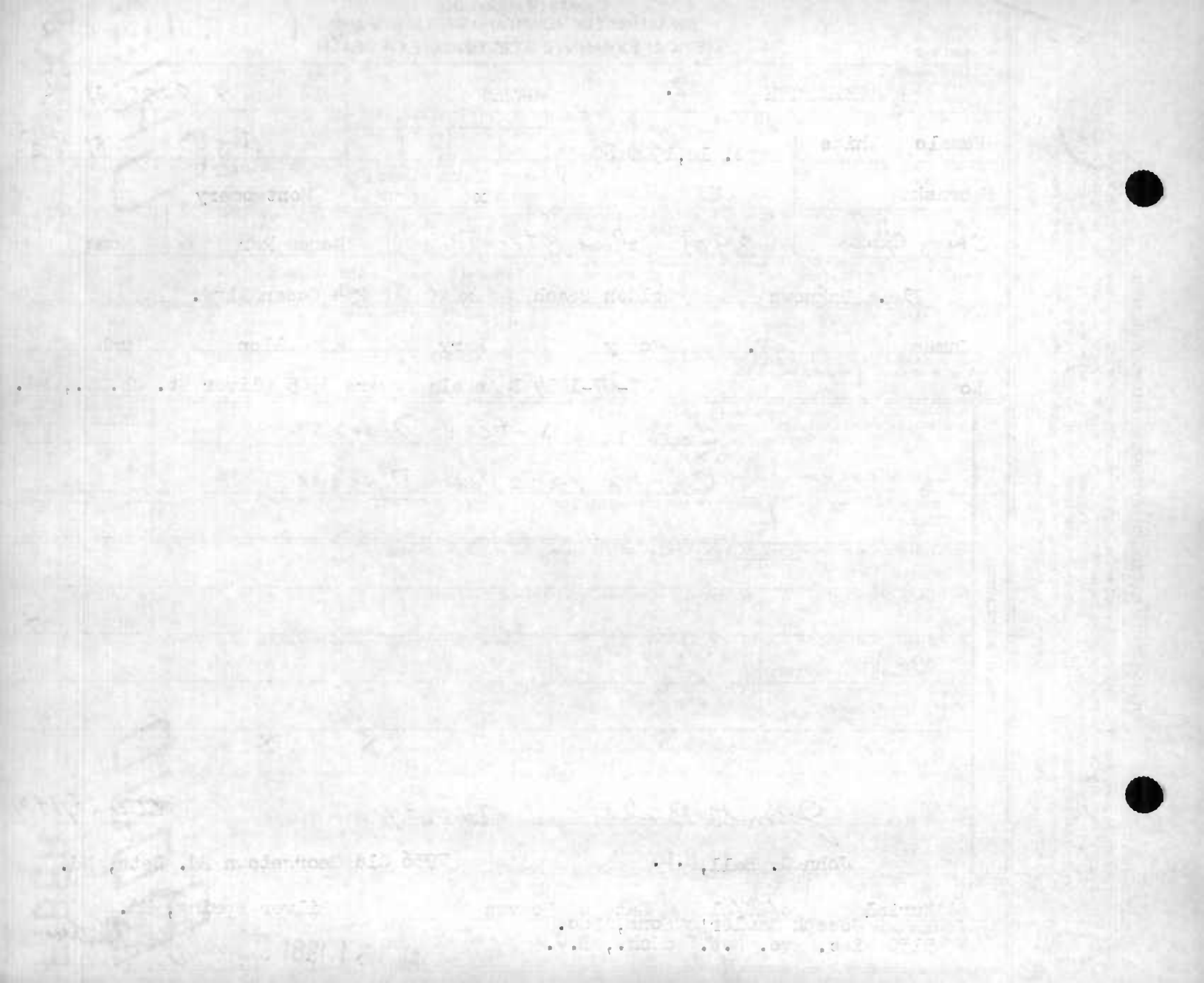


TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE EXAMINER SHOULD WRITE "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR THE DIVISION OF VITAL RECORDS. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
15M 7/76

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 21576	
1. DECEASED NAME (TYPE OR PRINT) MARGUERITE R. BATES										2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> 8-25-81	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Sept. 12, 1900		6. AGE (IN YEARS) LAST BIRTHDAY 80 YRS.		7c. DATE PRONOUNCED DEAD Aug 25 1981		7b. HOUR A.M.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Nebraska				7b. CITIZEN OF WHAT COUNTRY? US				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Chesapeake				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3905 Oliver Street				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Home	
13a. STATE Fla.				13b. COUNTY Unknown		13c. CITY OR TOWN Golden Beach		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET ADDRESS 254 Ocean Blvd.	
14. FATHER'S NAME FIRST MIDDLE LAST James F. Roddy				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Ellen Rush				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No			
16b. SOCIAL SECURITY NO. 577-07-1414				17. INFORMANT ADDRESS Angela Powers 3905 Oliver St. Ch.Ch., Md.				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 4149 IMMEDIATE CAUSE (a) Coronary Artery Disease. DUE TO, OR AS A CONSEQUENCE OF (b) Cardio Vascular Disease DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE John G. Ball				TITLE (SPECIFY) Deputy M.D.				DATE SIGNED Aug 25, 1981			
EXAMINER'S NAME (TYPE OR PRINT) John G. Ball, M.D.				ADDRESS 7936 Old Georgetown Rd. Beth, Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 8/28/81		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven				23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring, Md.	
24. FUNERAL DIRECTOR NAME Joseph Gawler's Sons, Inc.				ADDRESS 5130 Wisc. Ave. N.W. Wash., D.C.				25a. DATE REC'D. BY REGISTRAR AUG 31 1981		25b. REGISTRAR'S SIGNATURE Frances Santhorne	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked at item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 1 2 1 5 7 7			
1. FOR STATE REGISTRAR		REG. NO.											
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR
MABEL P. BAUS								8-22-81					4:45 P
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS			
FEMALE		WHITE		OCT. 31, 1896		84 YRS		MONTHS		DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
PENNSYLVANIA		USA				MONTGOMERY CO.						MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
ROCKVILLE		NATIONAL LUTHERAN HOME FOR THE AGED- ORGANIST		AGED- ORGANIST		MUSIC							
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. CITY OR TOWN		13c. INSIDE CITY LIMITS?		13d. STREET ADDRESS							
VIRGINIA		FAIRFAX		SPRINGFIELD		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		8118- BULLOCK ROAD					
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME											
DAVID ENSMINGER		HANNA											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS							
NO		219-34-9323A		REV. DR. RICHARD REICHARD - NLH - ROCKVILLE, MD									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> <u>4140</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (b) <u>arteriosclerotic heart disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>10 yrs</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from <u>Mar. 1, 1973</u> to <u>Aug. 22, 1981</u> , that (I) (we) last saw the deceased alive on <u>Aug. 22, 1981</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED							
<u>Harold F. McCann, M.D.</u>						AUG. 22, 1981							
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS											
HAROLD F. McCANN, M.D.		3355-16th ST., NW WASH., DC											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE							
BURIAL		AUG. 26, 1981		GEORGE WASH. CEMETERY		HYATTSVILLE, MARYLAND							
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
HYSONG FUNERAL HOME-		1300- N ST., NW WASH., DC		AUG 31 1981		<u>James J. [Signature]</u>							

1. 52 - 12

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8 1 2 1 5 7 8	
1- FOR STATE REGISTRAR					CERTIFICATE OF DEATH						
1 DECEASED NAME (TYPE OR PRINT)					2a DATE OF DEATH					2b HOUR	
FIRST MIDDLE LAST Odus Clyde Beadles					MONTH DAY YEAR August 19, 1901					1730 P.M.	
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		7 IF UNDER 1 YEAR		7b IF UNDER 72 HRS.	
Male		white		MONTH DAY YEAR Oct. 2 1903		XXXXXXXXXX 77 YRS		MONTHS DAYS		HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Texas		USA				Montgomery MD.					
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a USUAL OCCUPATION (TYPE OF WORK OR BEST OF WORKING LIFE)			12b KIND OF BUSINESS OR INDUSTRY		
Takoma Park		Washington Adventist Hosp.				Ret. Driver			Metro		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13d INSIDE CITY LIMITS?		13e STREET ADDRESS				
13a STATE		13b COUNTY		13c CITY OR TOWN		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		7915 Woodbury Drive,			
Maryland		Montgomery		Sil. Spring							
14. FATHER'S NAME FIRST MIDDLE LAST					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST						
John Beadles					Lucy Brannom						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b SOCIAL SECURITY NO.		17 INFORMANT (wife) ADDRESS				
no					578-10-5578		Maurine V. Beadles-(same as 13e)				
18 CAUSE OF DEATH (Enter only one cause per line for (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u> <u>4349</u> DUE TO, OR AS A CONSEQUENCE OF: (b) <u>Pneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <u>Perinatal infarct</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>sherry</u>											
19a DATE OF OPERATION					CONDITION FOR WHICH OPERATION WAS PERFORMED					20a AUTOPSY?	
										YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>					21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE				
22a I certify that (a) (this hospital) attended the deceased from <u>7-24</u> 19 <u>81</u> to <u>8-19</u> 19 <u>81</u> and that (b) (we) lost saw the deceased <u>die</u> on <u>8-19</u> 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated (above) (and) (did not) (did not) view the body after death.										22c DATE SIGNED <u>8/20/81</u>	
22b SIGNATURE <u>John L Ford MD</u>					DEGREE ATTENDING PHYSICIAN MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						
22d PHYSICIAN'S NAME (TYPE OR PRINT) <u>JOHN L FORD MD</u>					22e ADDRESS <u>344 University Blvd W. Silver Spring, Md 20907</u>						
23a BURIAL, CREMATION, REMOVAL (SPECIFY)			23b DATE		23c NAME OF CEMETERY OR CREMATORY			23d LOCATION CITY OR TOWN COUNTY STATE			
Burial			8-22-1981		Washington Cemetery			Suitland Pr. Georges Md.			
24 FUNERAL DIRECTOR Warner E. Pumphrey, Inc. 8434 Ga. Ave., S.S. Md.					25a DATE REC'D. BY REGISTRAR			25b REGISTRAR'S SIGNATURE <u>John E. Wilson</u>			
					AUG 25 1981						

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Takoma Par.

Maryland Monr

John

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office of the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 2 1 5 7 9

REG. NO.

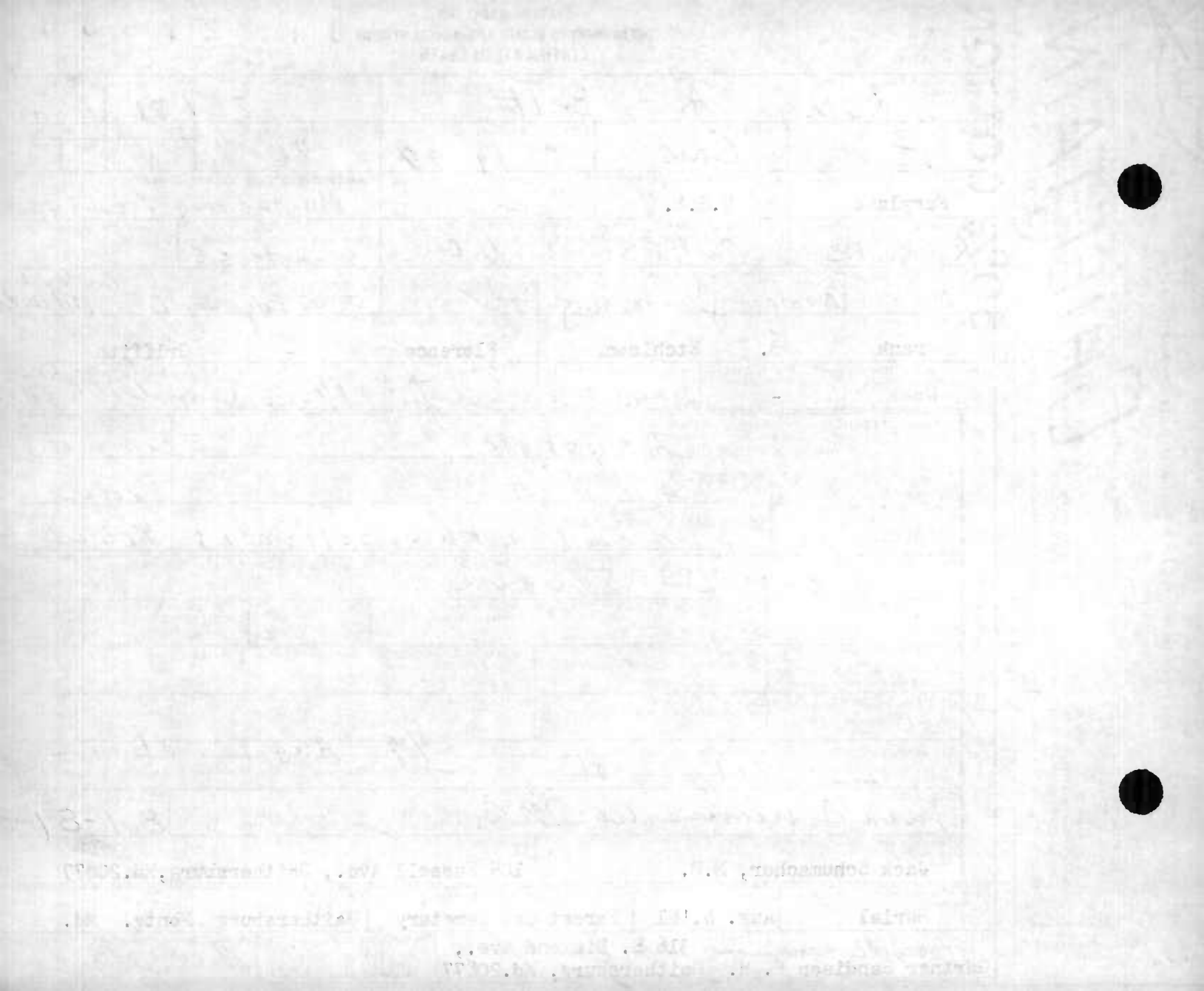
1. DECEASED NAME (TYPE OR PRINT) Gertrude Beck			2a. DATE OF DEATH MONTH DAY YEAR August 1, 1981		2b. HOUR 2:48am
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Nov. 17, 1913		6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Olney	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Pract. Nurse	12b. KIND OF BUSINESS OR INDUSTRY Elderly	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE Maryland		13b. COUNTY Montgomery	13c. CITY OR TOWN Silver Sp.	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS 3608 Bel Pre Road
14. FATHER'S NAME FIRST MIDDLE LAST Daniel C. Barnes		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Hattie Day		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No	
16b. SOCIAL SECURITY NO. 220-03-1457		17. INFORMANT Marcia Gillis		ADDRESS 632 Davis Road Mt. Airy, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure 4920 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Emphysema DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION 2/19		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 7/18 , 19 81 to 8/1 , 19 81 , that (I) (we) last saw the deceased alive on 7/19 , 19 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Jay Weiner MD		DEGREE		22c. DATE SIGNED 8/1/81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jay Weiner MD		22e. ADDRESS 50 W Edmonson Dr Rockville Md			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 8/3/81	23c. NAME OF CEMETERY OR CREMATORY Mt. Olive		23d. LOCATION CITY OR TOWN COUNTY STATE Mt. Airy Maryland	23e. DATE REGD. BY REGISTRAR (25) REGISTRAR'S SIGNATURE AUG 4 1981
24. FUNERAL DIRECTOR NAME Olin L. Molesworth, P.A., Damascus, Md.		ADDRESS			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8 1 2 1 5 8 0	
1. FOR STATE REGISTRAR					REG. NO.						
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Ruth A. Belt					2a. DATE OF DEATH MONTH DAY YEAR 8 1 81				2b. HOUR 6:15 AM		
3. SEX F		4. RACE Cau.		5. DATE OF BIRTH MONTH DAY YEAR 8 19 94		6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.					
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Collingswood N.C.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Seamstress			12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Md.			13b. COUNTY Montgomery		13c. CITY OR TOWN Gaithersburg		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 9300 Edgewood Dr. Md. 20870		
14. FATHER'S NAME FIRST MIDDLE LAST Frank B. Etchison					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Florence - Griffith						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 213-40-8031		17. INFORMANT ADDRESS Wm. Swyer, Jr. M.D. - Collingswood N.C. wife					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asystole 4140 DUE TO, OR AS A CONSEQUENCE OF (b) A.S.H.D. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) Heart &therosclerosis APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Seconds Years Years											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) C.O.P.D - Severe											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22. I certify that (I) (this hospital) attended the deceased from 7-1 19 81 , to Aug. 1 19 81 , that (I) (we) last saw the deceased alive on 7-1 19 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.											
23. SIGNATURE Jack Schumacher M.D.						DEGREE MD			22c. DATE SIGNED 8-1-81		
23d. PHYSICIAN'S NAME (TYPE OR PRINT) Jack Schumacher, M.D.						22e. ADDRESS 105 Russell Ave., Gaithersburg, Md. 20877					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Aug. 4, '81		23c. NAME OF CEMETERY OR CREMATORY Forest Oak Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Gaithersburg Montg. Md.			
24. FUNERAL DIRECTOR Robert Sandison						25a. DATE REC'D. BY REGISTRAR AUG 6 1981			25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>		
24. FUNERAL DIRECTOR Gartner Sandison F. H.						25a. DATE REC'D. BY REGISTRAR AUG 6 1981			25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>		





STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1- FOR STATE REGISTRAR					REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) DAVID BERKOWITZ					2a. DATE OF DEATH MONTH DAY YEAR August 18, 1981			2b. HOUR 8:45pm		
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Dec. 28, 1898		6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Roumania		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.				
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Collingswood Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Owner (Ret)		12b. KIND OF BUSINESS OR INDUSTRY Restaurant		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) Maryland					13b. COUNTY Montgomery		13c. CITY OR TOWN Gaithersburg		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Samuel Berkowitz					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rachel (unknown)					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW I		17. INFORMANT Samuel Berkowitz; 5981 Gales Lane		18. ADDRESS Columbia, Md.				
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH)										
6000 DUE TO, OR AS A CONSEQUENCE OF Urinary tract infection (b) _____ DUE TO, OR AS A CONSEQUENCE OF Prostatism, general debility (c) _____										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. a. Fracture L & R hips (OPI) Fibrosis R Hip										
19a. DATE OF OPERATION May 11, 1981		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Fracture R Hip (ft)				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> HOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from August 17, 1981 to August 18, 1981 that (I) (we) last saw the deceased alive on Aug. 17, 1981 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) not see the body after death, so state.)										
22b. SIGNATURE <i>Thomas O. Garvey, III</i>		22c. PHYSICIAN'S NAME (TYPE OR PRINT) THOMAS O. GARVEY, III, M.D.				22d. ADDRESS 11510 Old Georgetown Rd., Rockville		22e. DATE SIGNED 8-19-81		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 8-20-81		23c. NAME OF CEMETERY OR CREMATORY Lee Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Washington D.C.				
24. FUNERAL DIRECTOR NAME ADDRESS Danzansky-Goldberg Chapels; 1170 Rockville Pike										



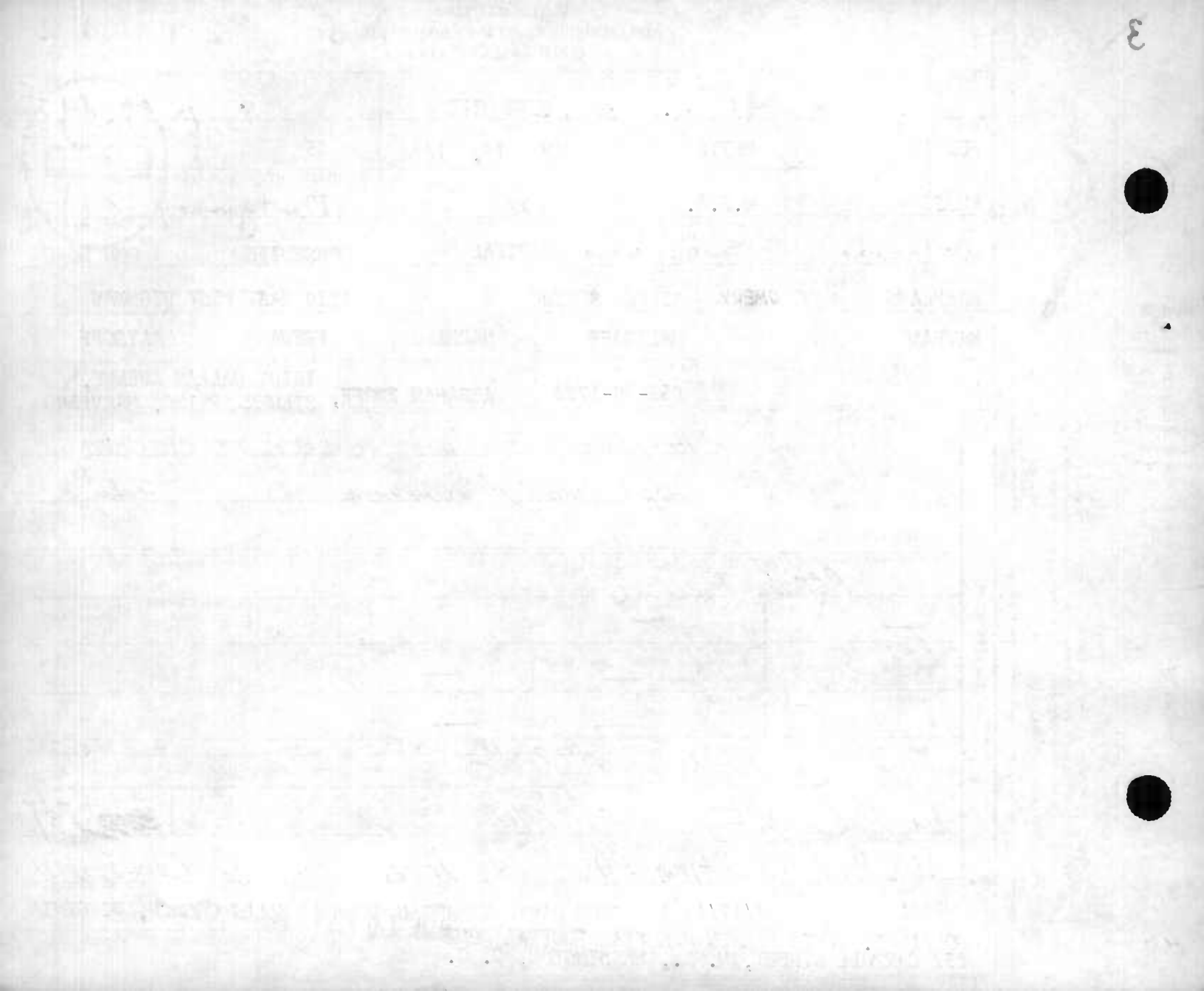
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the informant, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8 1 2 1 5 8 2	
1 - STATE REGISTRAR										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST SADIE I. BERKOWITZ					2a. DATE OF DEATH MONTH DAY YEAR 8 15 81		2b. HOUR 10 45 P.M.				
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR MAY 10, 1896		6. AGE (IN YEARS LAST BIRTHDAY) 85		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		IF UNDER 24 HRS.	
7a. BIRTHPLACE COUNTRY (STATE OR FOREIGN) RUSSIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery		MD.			
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY OWN HOME			
13a. STATE MARYLAND		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN SILVER SPRING		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1220 EAST WEST HIGHWAY			
14. FATHER'S NAME FIRST MIDDLE LAST NATHAN MALISOFF				15. MOTHER'S MAIDEN NAME NACHAME FREDA MALISOFF							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 053-09-1788		17. INFORMANT ADDRESS 10107 DALLAS AVENUE, ABRAHAM IROFF, SILVER SPRING, MARYLAND							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Aspiration Pneumonia DUE TO, OR AS A CONSEQUENCE OF (c) Renal Failure										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day 5 days	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a											
19a. DATE OF OPERATION 5070		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Renal Failure				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (1) (this hospital) attended the deceased from Aug 15 , 19 81 , to Aug 15 , 19 81 , that (we) last saw the deceased alive on Aug 15 , 19 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Ira Paul Krefting				DEGREE MD				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED Aug 16 1981	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Ira Paul Krefting MD				22e. ADDRESS 1811 Prince Philip Dr Olney MD							
23a. BURIAL, CREMATION, REMOVAL BURIAL		23b. DATE 8/17/1981		23c. NAME OF CEMETERY OR CREMATORY KING DAVID MEMORIAL FUNERAL HOME		23d. LOCATION FALLS CHURCH, VIRGINIA					
24. FUNERAL DIRECTOR DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME 232 CARROLL STREET, N. W., WASHINGTON, D. C.											



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed without removal of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

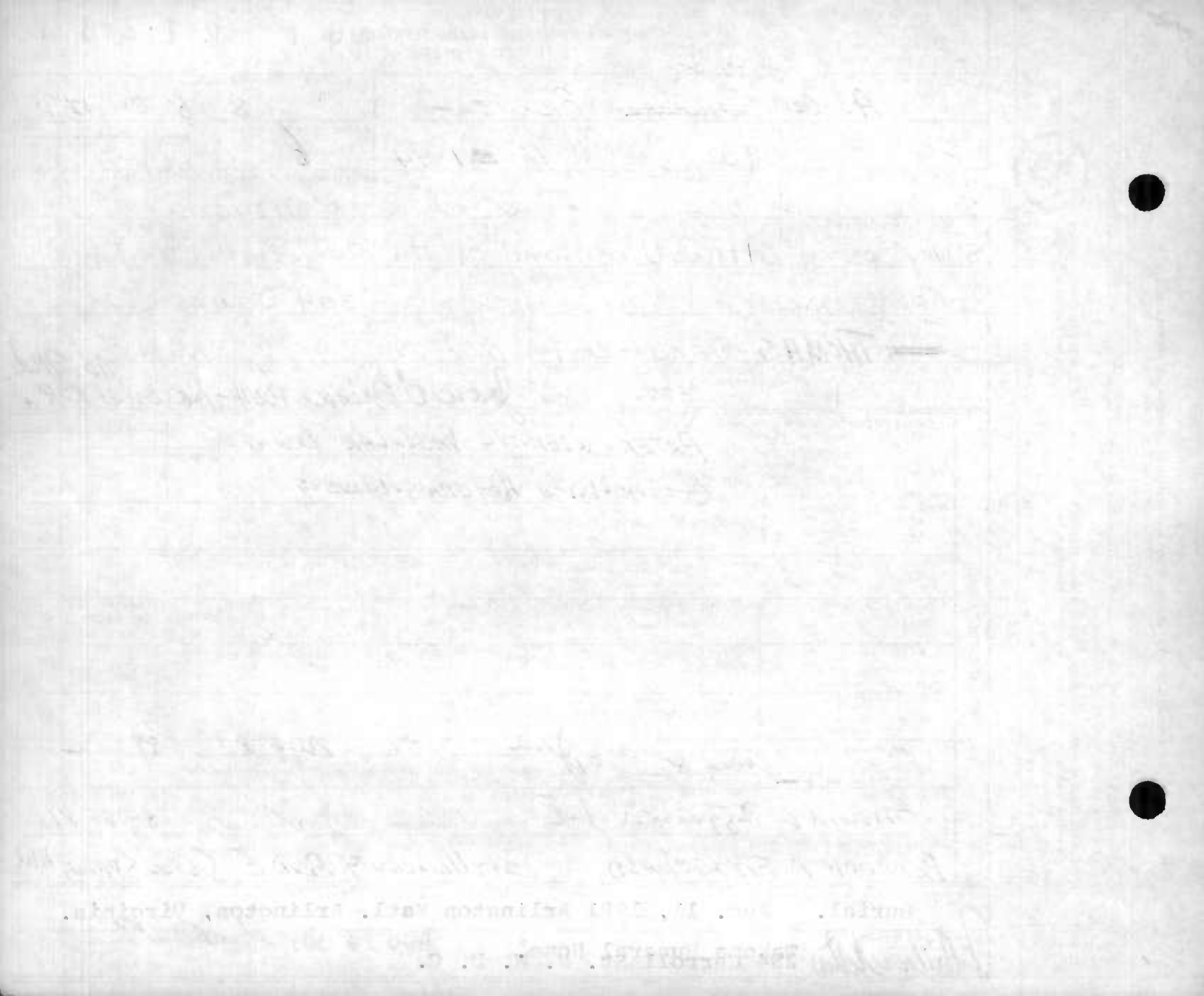
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DHMH - 16 60M / 175
(VRA 15 (4))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 1 2 1 5 8 3
CERTIFICATE OF DEATH

1. FOR STATE REGISTRAR		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Beatrice ALICE SANDERS BICKNELL</i>		2a. DATE OF DEATH MONTH DAY YEAR <i>8 8 81</i>	
3. SEX <i>F.</i>	4. RACE <i>Cauc.</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>12-1-94</i>	6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS <i>86</i>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Stephen, Minn.</i>	7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH <i>Silver Spring</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>at the Woodland, N. H.</i>	9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery</i> MD.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>College English Teacher</i>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <i>MD.</i>	13b. COUNTY <i>Mont.</i>	13c. CITY OR TOWN <i>Silver Spring</i>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST <i>THOMAS SANDERSON</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Matilda Miller</i>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO <i>578-30-9068</i>	17. INFORMANT ADDRESS <i>Joan O'Brien 1304-Downs Dr.</i>	
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>ARTERIOSCLEROTIC VASCULAR DISEASE</i> <i>4409</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>GENERALIZED ARTERIOSCLEROSIS</i> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):			
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>Jan 81</i> to <i>Aug 81</i> , that (we) last saw the deceased alive on <i>Aug 8</i> , 19 <i>81</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <i>Bernard A. Fitzgerald MD</i>		22c. DATE SIGNED <i>8-8-81</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>BERNARD A. FITZGERALD</i>		22e. ADDRESS <i>217 UNIVERSITY BLVD E. SILVER SPRING MD</i>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial.</i>	23b. DATE <i>Aug. 11, 1981</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Arlington Natl.</i>	23d. LOCATION CITY OR TOWN COUNTY STATE <i>Arlington, Virginia.</i>
24. FUNERAL DIRECTOR (NAME) <i>Takoma Funeral Home</i> <i>254 Carroll St. N. W. D. C.</i>			



BH

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 2 1 5 8 4

1- FOR
STATE
REGISTRAR

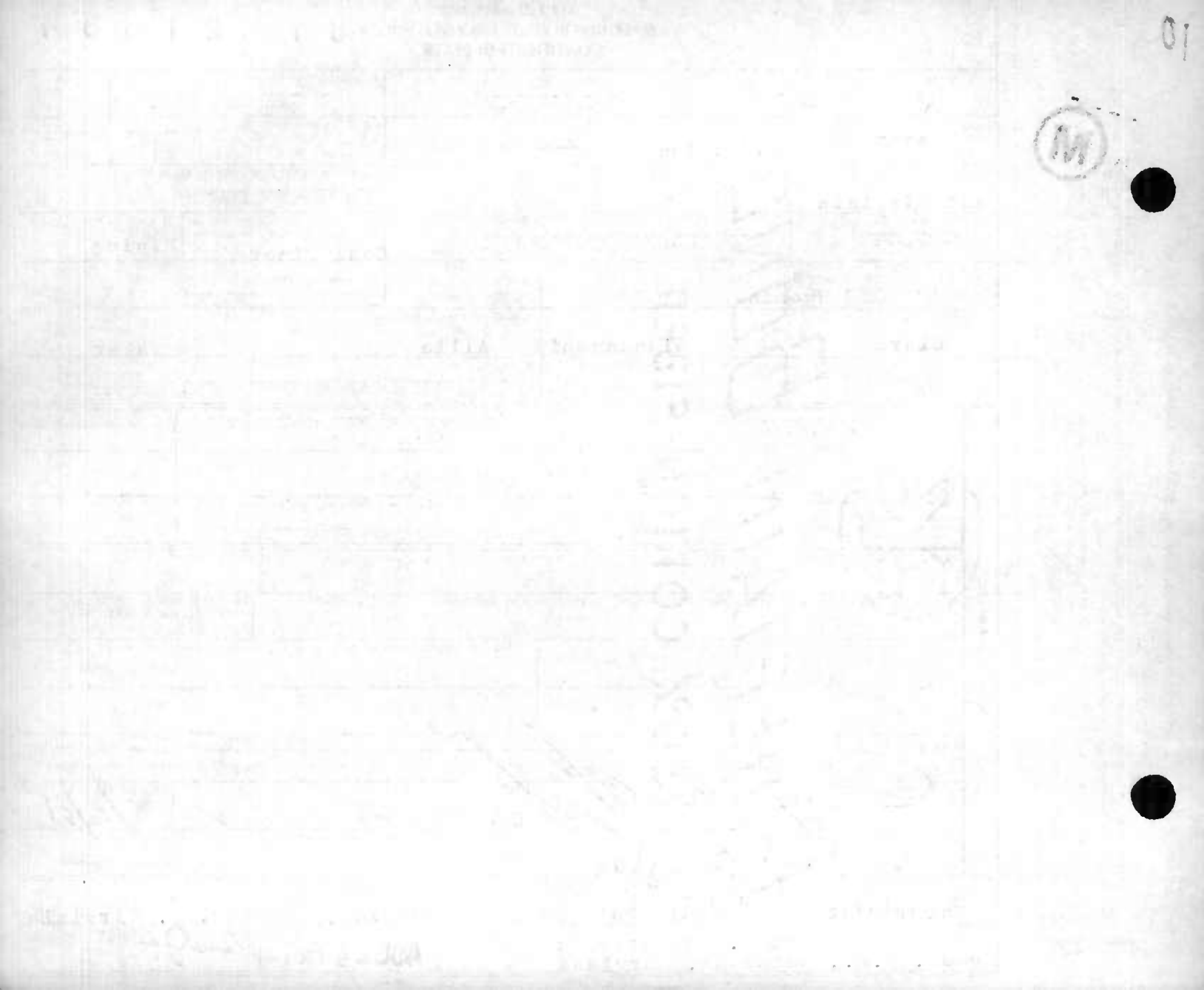
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) LACY BLANKENSHIP			2a. DATE OF DEATH MONTH DAY YEAR AUGUST 15, 1981		2b. HOUR 8:02^P M	
3. SEX MALE	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR MARCH 3, 1927		6. AGE (IN YEARS LAST BIRTHDAY) 54		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION THE CLINICAL CENTER, NIH		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE WEST VIRGINIA		13b. CITY OR TOWN WYOMING SAULSVILLE		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Clark		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Allie Baker		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Coal Miner		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 235-36-9032		17. INFORMANT ADDRESS MRS. BIRCHIE BLANKENSHIP (NOK) SAME AS ABOVE		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) to hemorrhagic pneumonitis DUE TO, OR AS A CONSEQUENCE OF (b) Intraabdominal carcinomatosis DUE TO, OR AS A CONSEQUENCE OF (c) metastatic adenocarcinoma of stomach. Status post esophagojejunostomy APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1519 days weeks months						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: CONTRIBUTING TO DEATH						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from JULY 24, 1981 to AUGUST 15, 1981 , that (I) (we) lost saw the deceased alive on AUGUST 15, 1981 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <i>[Signature]</i>		22c. ADDRESS NATIONAL INSTITUTES OF HEALTH CLINICAL CENTER, BETHESDA, MARYLAND 20205		22d. DATE SIGNED 8/16/81		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Weiland, Douglas		22e. ADDRESS NATIONAL INSTITUTES OF HEALTH CLINICAL CENTER, BETHESDA, MARYLAND 20205		22f. DATE SIGNED 8/16/81		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Entombment		23b. DATE August 1981		23c. NAME OF CEMETERY OR CREMATORY Palm Memorial Gardens, Matheny, W. Virginia		
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Homes, P.A., Bethesda, Maryland		25a. DATE REC'D. BY REGISTRAR AUG 24 1981		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 1B shows any injury, or other traumatic event, the medical examiner must be notified.



Cleared By Mob. Examiner

DHMH - 16 50M 1/81
(VRA 15, 4)

Page 4 may be retained by the hospital or attending physician.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

FOR STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 1 2 1 5 8 5			
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH				2b. HOUR			
John W Boothe				07 30 81				4:04 A.M.			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
M		Black		9 24-65 75		75		MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Va		U.S.A.				Montgomery MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
Silver Spring		Holy Cross Hospital									
13a. USUAL RESIDENCE (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		13b. CITY OR TOWN		13c. INSIDE CITY LIMITS?		13d. STREET ADDRESS					
N.C.		Wash.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		906 T. N. Ave					
14. FATHER'S NAME (TYPE OR PRINT)		15. MOTHER'S MAIDEN NAME (TYPE OR PRINT)		16. SOCIAL SECURITY NO.		17. INFORMANT (TYPE OR PRINT)					
John		Boothe				Raymond Baith		1532 Hampton			
18. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES)		19. SOCIAL SECURITY NO.		20. INFORMANT (TYPE OR PRINT)		21. ADDRESS					
yes		A									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) cardiac arrest											
DUE TO, OR AS A CONSEQUENCE OF (b) arteriosclerotic vascular disease											
DUE TO, OR AS A CONSEQUENCE OF (c) renal insufficiency											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:											
Carcinoma of prostate											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
								YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
				P.M. 19							
21d. INJURY OCCURRED (WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>)				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION (STREET CITY OR TOWN COUNTY STATE)			
22a. I certify that (I) (the hospital) attended the deceased from May 21, 19 81, to July 30, 19 81, that (we) lost saw the deceased alive on July 16, 19 81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (we) (we) (did not) view the body after death.											
22b. SIGNATURE				DEGREE				22c. DATE SIGNED			
Walter E. Goode MD				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				30 July 81			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS							
WALTER E. GOODE MD				2309 Shorefield Road Wheaton MD							
23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (CITY OR TOWN COUNTY STATE)			
Burial				8-5-81		Preston Park		Newport News, VA			
24. FUNERAL DIRECTOR (NAME)				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE			
W. H. Bacon				3447-14th St, NW				AUG 17 1981			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health department within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified before the body is released for burial or cremation.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 1 2 1 5 8 6			
1 - FOR STATE REGISTRAR				REG. NO.			
1 DECEASED NAME (TYPE OR PRINT) James DANA BOWSER				2a DATE OF DEATH August 10 1981		2b HOUR 10:50P ^M	
3 SEX Male		4 RACE Caucasian		5 DATE OF BIRTH Nov. 3 1924		6 AGE (IN YEARS LAST BIRTHDAY) 56 YRS.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10 CITY OR TOWN OF DEATH Bethesda		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) National Naval Medical Center		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) U. S. Navy		12b KIND OF BUSINESS OR INDUSTRY Electrician	
13a STATE Pennsylvania 13b COUNTY Chambersburg 13c CITY OR TOWN Green Castle				13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS 10714 Scenic View	
14 FATHER'S NAME James Maurice Bowser				15 MOTHER'S MAIDEN NAME Virginia B. Conley			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b SOCIAL SECURITY NO. 1942-72		17 INFORMANT Toshimi Bowser		ADDRESS See item 13	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 1629 Pulmonary edema & Bronchopneumonia Adenocarcinoma of the lung Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) _____ (c) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c)							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY 19 HOUR A.M. MONTH DAY YEAR P.M.		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from August 8 , 19 81 , to August 10 , 19 81 that (I) (we) lost saw the deceased alive on August 10 , 19 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b SIGNATURE Gary G. Sladek DEGREE MD				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c DATE SIGNED Aug. 11, 1981	
22d PHYSICIAN'S NAME (TYPE OR PRINT) Gary G. Sladek				22e ADDRESS National Naval Medical Center, Bethesda, Md.			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b DATE Aug 11, 1981		23c NAME OF CEMETERY OR CREMATORY Smithsburg Crematory		23d LOCATION CITY OR TOWN Smithsburg, Wash, Md. COUNTY STATE	
24 FUNERAL DIRECTOR NAME Osborne Funeral Home, Williamsport, Md.				25a DATE REC'D. BY REGISTRAR AUG 17 1981		25b REGISTRAR'S SIGNATURE <i>James J. [Signature]</i>	

BP _____

(14)

Aug 11, 1961 Interservice Committee, Arlington, Wash, D.C.

AUG 11 1961

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 2 1 5 8 7

FOR
1 - STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Paul Lawrence BRAUN			2a. DATE OF DEATH MONTH DAY YEAR Aug. 13, 1981		2b. HOUR 2:10A M		
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Dec. 10, 1900		6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery Co., MD.	
10. CITY OR TOWN OF DEATH Gaithersburg		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 23804 Pleasant View Lane		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Household manager		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)							
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Gaithersburg		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET ADDRESS 23804 Pleasant View Lane							
14. FATHER'S NAME FIRST MIDDLE LAST Paul				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Helena Griesner			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212-03-2147		17. INFORMANT ADDRESS Lucy Burdette Braun, Item 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) C.V.A. 4140 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) C.V.D. DUE TO, OR AS A CONSEQUENCE OF (c) Atherosclerosis							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 days
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) A.F. due to A.S.I.D.							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 1958 19 8-13 19 81 , that (I) was lost saw the deceased alive on 8-11-81 , and that in (my) own opinion death occurred on the date and hour and from the causes stated above, (I) was (did) not view the body after death.							
22b. SIGNATURE Jack Schumacher				22c. DATE SIGNED Aug. 13, 1981		22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
22e. PHYSICIAN'S NAME (TYPE OR PRINT) Jack Schumacher, M.D.				22f. ADDRESS 105 Russell Ave., Gaithersburg, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Aug. 15, 1981		23c. NAME OF CEMETERY OR CREMATORY Wesley Grove		23d. LOCATION CITY OR TOWN COUNTY STATE Woodfield, Montgomery, Md.	
24. FUNERAL DIRECTOR Orin L. Molesworth, P.A.,				25a. DATE RECD. BY REGISTRAR AUG 17 1981		25b. REGISTRAR'S SIGNATURE James J. Harrison	

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical certification completed.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 1 2 1 5 8 8			
1- FOR STATE REGISTRAR				CERTIFICATE OF DEATH			
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH			
Mattie R. Brewer				8/12/81			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	
Female		Caucasian		01 16/1900		81 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Virginia		USA				Montgomery MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Rockville, Md		Shady Grove Adventist Hosp.		Housewife		Own Home	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13d. INSIDE CITY LIMITS?			
Maryland Montgomery Gaithersburg				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME (FIRST MIDDLE LAST)		15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST)		13c. STREET ADDRESS			
Samuel Riffey		Lucinda Woods		30 Delmar St.			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS			
No		232-96-5108		Forest, Md. Glen C. Brewer 8004 Boundrey Dr.			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CHOLANGITIS 1579 DUE TO, OR AS A CONSEQUENCE OF (b) COMMON BILE DUCT STRICTURE DUE TO, OR AS A CONSEQUENCE OF (c) PANCREATIC CARCINOMA							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 17 DAYS UNKNOWN UNKNOWN
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: HYPOTHYROIDISM; DISEMINATED INTRAVASCULAR COAGULATION							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
NONE				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the hospital) attended the deceased from 7/28, 1981, to 8/11, 1981, that (I) (we) last saw the deceased alive on 8/11, 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE ALAN N. SCHULMAN, M.D.		DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8/12/81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS					
ALAN N. SCHULMAN, M.D.		9915 MEDICAL CENTER DRIVE, Suite 404 ROCKVILLE, MD. 20850					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial		8-15-81		Green Cove Cemetery		Washington Va.	
24. FUNERAL DIRECTOR NAME				ADDRESS		25a. DATE REC'D. BY REGISTRAR	
Johnson Funeral Home				Damascus, Va.		AUG 21 1981	



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 1 2 1 5 8 9	
1. FOR STATE REGISTRAR										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) Lawrence Franklin Brill						2a. DATE OF DEATH MONTH DAY YEAR August 26, 1981			2b. HOUR 8:50a M		
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR July 17, 1924		6. AGE (IN YEARS LAST BIRTHDAY) 57 YRS			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. IF UNDER 24 HRS.		
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) W. Va.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.					
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Clinical Center, NIH, Bethesda, Md				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Welder			12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Virginia		13b. COUNTY Winchester		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS Box 70, Siler Route					
14. FATHER'S NAME FIRST MIDDLE LAST Oscar Brill				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bertha Miller							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWII		17. INFORMANT Eva Mae Brill (wife)		ADDRESS same					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary arrest 1509 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Respiratory failure due to abscess rupture (c) Metastatic esophageal carcinoma										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH < 30 min. < 24 hr > 4 yr	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).											
19a. DATE OF OPERATION 8/25/81		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Small bowel obstruction				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I, OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from August 11, 1981 , to August 26, 1981 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on August 26, 1981 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) did <input type="checkbox"/> (not) view the body after death.											
22b. SIGNATURE John H. Donohue, MD.				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 8/26/81			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John H. Donohue, MD.				22e. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal		23b. DATE 8/27/81		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE Winchester Virginia					
24. FUNERAL DIRECTOR NAME ADDRESS Hines/Rinaldi F.H. 11800 N.H. Ave. S.S. Md.						25a. DATE REC'D. BY REGISTRAR AUG 31 1981					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrars, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) Raymond Arthur Bruneau			2a DATE OF DEATH MONTH 8 DAY 4 YEAR 81		2b HOUR 8:00 P/M
3 SEX Male	4 RACE white	5 DATE OF BIRTH MONTH 5 DAY 16 YEAR 1912	6 AGE (IN YEARS LAST BIRTHDAY) 69	IF UNDER 1 YEAR MONTHS 0 DAYS 0	IF UNDER 24 HRS HOURS 0 MIN. 0
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Connecticut	7b CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.		
10 CITY OR TOWN OF DEATH Rockville	11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 13510 Bailey Drive		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) retired Administ. Asst. Supt. of Police		12b KIND OF BUSINESS OR INDUSTRY
13a STATE Maryland	13b COUNTY Montgomery	13c CITY OR TOWN Rockville	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET ADDRESS 13510 Bailey Drive	
14 FATHER'S NAME FIRST Arthur MIDDLE Magloire LAST Bruneau			15 MOTHER'S MAIDEN NAME FIRST Mathilda MIDDLE Hupe LAST Hupe		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes		16b SOCIAL SECURITY NO. 725-12-4444		17 INFORMANT ADDRESS AnneJo T. Bruneau same as 13e	
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) pulmonary edema DUE TO, OR AS A CONSEQUENCE OF (b) diffuse carcinomatous DUE TO, OR AS A CONSEQUENCE OF (c) carcinoma, adeno, gland					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3-4 hours 4-5 minutes 2 years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: none					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR 5 P.M. MONTH 8 DAY 4 YEAR 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET 50 W. Edmonston Dr. CITY OR TOWN Rockville COUNTY Maryland STATE MD	
22 I certify that (I) (this hospital) attended the deceased from Aug 4 1981 to Aug 4 1981 , that (I) (we) last saw the deceased alive on Aug 4 1981 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (did) (did not) view the body after death.					
22a PHYSICIAN'S NAME (TYPE OR PRINT) G. Bowditch Hunter		22b ADDRESS 50 W. Edmonston Dr. Rockville, Maryland		22c DATE SIGNED 8/5/81	
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b DATE 8/7/81		23c NAME OF CEMETERY OR CREMATORY Metropolitan Crematory	
24 FUNERAL DIRECTOR NAME Tyson Wheeler Funeral Home, Inc.		25a DATE REC'D. BY REGISTRAR AUG 10 1981		25b REGISTRAR'S SIGNATURE <i>[Signature]</i>	
23d LOCATION CITY OR TOWN Alexandria COUNTY Virginia STATE VA					

1- FOR
STATE
REGISTRAR

Lisa Marguerite Bulkley

CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Marguerite Bulkley			2a. DATE OF DEATH MONTH DAY YEAR 08 17 81			2b. HOUR 2:30a M				
3 SEX Female		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR April 10-1914		6 AGE (IN YEARS LAST BIRTHDAY) 67 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Sweden		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.				
10. CITY OR TOWN OF DEATH Olney		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.			13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Sp.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 3233 So Leisure World Blvd.	
14. FATHER'S NAME MIDDLE LAST William Peterson			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nana Hagblad							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) None		17. INFORMANT 17302 Sandy Knoll Dr. 20832 Deborah Tippit-daughter Silver Sp., Md.					
18. CAUSE OF DEATH (Enter only one cause per line for a, b, and c) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 5602 Intestinal obstruction DUE TO, OR AS A CONSEQUENCE OF: b) Volvulus of Cecum DUE TO, OR AS A CONSEQUENCE OF: c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3d. 3-5d.										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Multiple myeloma, poorly responsive to chemotherapy										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 8/19/81 to 8/17/81 , that (I) (we) lost saw the deceased alive on 8/17/81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE [Signature] MD						DEGREE		22c. DATE SIGNED 8/17/81		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOHN G. LODMEU						22e. ADDRESS 18111 PRINCE PHILIP DR. OLNEY MD				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE 8-17-81		23c. NAME OF CEMETERY OR CREMATORY Lee's Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Washington, D.C. 20002			
24. FUNERAL DIRECTOR NAME Lee Funeral Home 300-4th St. N.E. Wash. D.C. 20002						24b. ADDRESS 300-4th St. N.E. Wash. D.C. 20002				

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified in writing.

MEDICAL CERTIFICATION

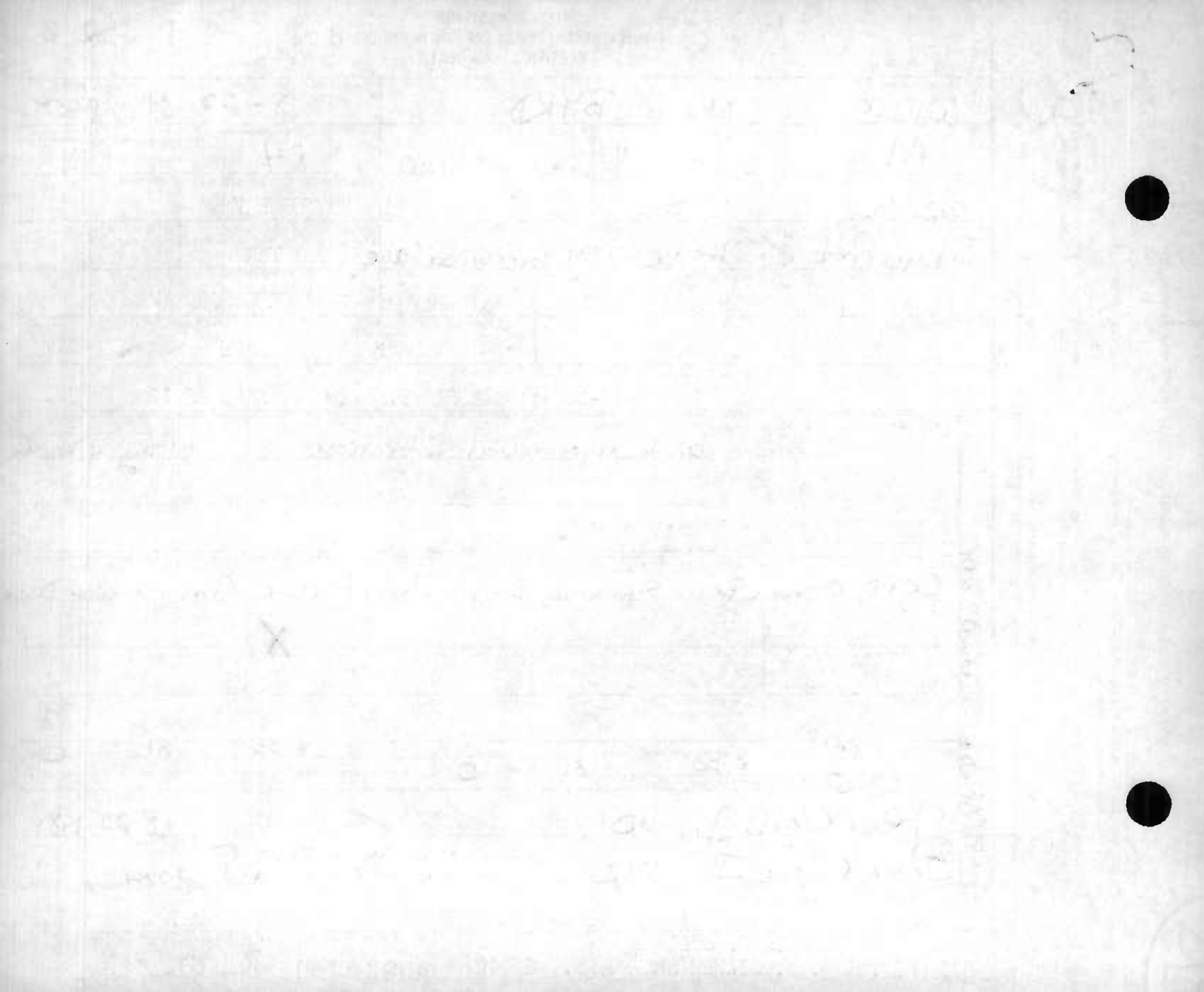
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE					8 1 2 1 5 9 2	
1. FOR STATE REGISTRAR					REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Carrie M Burton					2a. DATE OF DEATH MONTH DAY YEAR 8 25 81	
3. SEX Female		4. RACE B		5. DATE OF BIRTH MONTH DAY YEAR May 26, 1908		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash., D.C.		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN. 73 YRS.		
10. CITY OR TOWN OF DEATH Silver Sp.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Abing Cross Hosp.		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD.		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home				
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE COUNTY CITY OR TOWN DC DC WASH.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 726 Tewkesbury Pl NW Wash. D.C.		
14. FATHER'S NAME FIRST MIDDLE LAST (unk.)		15. MOTHER'S MAIDEN NAME FIRST MIDDLE Alberta (unk.)				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 578-09-2814		17. INFORMANT ADDRESS Leonard Gardner, Nephew 4014 5th St., N.W. Wash., D.C.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hepatic Failure 1550 DUE TO, OR AS A CONSEQUENCE OF (b) Hepatoma Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days 3 mo.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (a) (this hospital) attended the deceased from 5 19 81, to 8/25 19 81, that (b) (we) lost saw the deceased alive on 8/24 19 81, and that in my (our) opinion death occurred on the date and hour and from the causes stated above (b) (we) (did) (did not) view the body after death.						
22b. SIGNATURE Peter B. Sherer MD		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8/25/81		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) PETER B. SHERER MD		22e. ADDRESS 1109 Spring St. #610 Silver Spring MD 20910				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/29/81		23c. NAME OF CEMETERY OR CREMATORY Lincoln Memorial		
23d. LOCATION CITY OR TOWN COUNTY STATE Suitland Pr. Geo., Md.						
24. FUNERAL DIRECTOR NAME McGuire Funeral Ser., John F. Bollen		ADDRESS 7400 Ga. Ave., Wash., D.C.		25. DATE RECD. BY REGISTRAR SEP 01 1981		

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) WILLIS MARSHALL BYRD			2a. DATE OF DEATH MONTH DAY YEAR 8-22-81		2b. HOUR 8:45P ^M
3. SEX MALE	4. RACE CAUCASIAN	5. DATE OF BIRTH MONTH DAY YEAR Jan 25 1897		6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) XXXXXX Va	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.	
10. CITY OR TOWN OF DEATH Takoma Park	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOTHING SUCH FACILITY, GIVE STREET ADDRESS) Home-7731 Greenwood Ave		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) PAINTER		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE MARYLAND		13b. COUNTY MONTGOMERY	13c. CITY OR TOWN TAKOMA PARK	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 7731 GREENWOOD AVENUE
14. FATHER'S NAME FIRST MIDDLE LAST ALBERT T. BYRD			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY JANE PERRY		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 566-14-7508		17. INFORMANT ADDRESS BESSIE E. BYRD SAME AS 13 WIFE	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute myocardial infarction 4100 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Day of Death
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) COPD, Organic Brain Syndrome, Cerebral Vascular Disease					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (a) (b) (c) (d) (e) (f) (g) (h) (i) (j) (k) (l) (m) (n) (o) (p) (q) (r) (s) (t) (u) (v) (w) (x) (y) (z) (aa) (ab) (ac) (ad) (ae) (af) (ag) (ah) (ai) (aj) (ak) (al) (am) (an) (ao) (ap) (aq) (ar) (as) (at) (au) (av) (aw) (ax) (ay) (az) (ba) (bb) (bc) (bd) (be) (bf) (bg) (bh) (bi) (bj) (bk) (bl) (bm) (bn) (bo) (bp) (bq) (br) (bs) (bt) (bu) (bv) (bw) (bx) (by) (bz) (ca) (cb) (cc) (cd) (ce) (cf) (cg) (ch) (ci) (cj) (ck) (cl) (cm) (cn) (co) (cp) (cq) (cr) (cs) (ct) (cu) (cv) (cw) (cx) (cy) (cz) (da) (db) (dc) (dd) (de) (df) (dg) (dh) (di) (dj) (dk) (dl) (dm) (dn) (do) (dp) (dq) (dr) (ds) (dt) (du) (dv) (dw) (dx) (dy) (dz) (ea) (eb) (ec) (ed) (ee) (ef) (eg) (eh) (ei) (ej) (ek) (el) (em) (en) (eo) (ep) (eq) (er) (es) (et) (eu) (ev) (ew) (ex) (ey) (ez) (fa) (fb) (fc) (fd) (fe) (ff) (fg) (fh) (fi) (fj) (fk) (fl) (fm) (fn) (fo) (fp) (fq) (fr) (fs) (ft) (fu) (fv) (fw) (fx) (fy) (fz) (ga) (gb) (gc) (gd) (ge) (gf) (gg) (gh) (gi) (gj) (gk) (gl) (gm) (gn) (go) (gp) (gq) (gr) (gs) (gt) (gu) (gv) (gw) (gx) (gy) (gz) (ha) (hb) (hc) (hd) (he) (hf) (hg) (hh) (hi) (hj) (hk) (hl) (hm) (hn) (ho) (hp) (hq) (hr) (hs) (ht) (hu) (hv) (hw) (hx) (hy) (hz) (ia) (ib) (ic) (id) (ie) (if) (ig) (ih) (ii) (ij) (ik) (il) (im) (in) (io) (ip) (iq) (ir) (is) (it) (iu) (iv) (iw) (ix) (iy) (iz) (ja) (jb) (jc) (jd) (je) (jf) (jg) (jh) (ji) (jj) (jk) (jl) (jm) (jn) (jo) (jp) (jq) (jr) (js) (jt) (ju) (jv) (jw) (jx) (jy) (jz) (ka) (kb) (kc) (kd) (ke) (kf) (kg) (kh) (ki) (kj) (kk) (kl) (km) (kn) (ko) (kp) (kq) (kr) (ks) (kt) (ku) (kv) (kw) (kx) (ky) (kz) (la) (lb) (lc) (ld) (le) (lf) (lg) (lh) (li) (lj) (lk) (ll) (lm) (ln) (lo) (lp) (lq) (lr) (ls) (lt) (lu) (lv) (lw) (lx) (ly) (lz) (ma) (mb) (mc) (md) (me) (mf) (mg) (mh) (mi) (mj) (mk) (ml) (mm) (mn) (mo) (mp) (mq) (mr) (ms) (mt) (mu) (mv) (mw) (mx) (my) (mz) (na) (nb) (nc) (nd) (ne) (nf) (ng) (nh) (ni) (nj) (nk) (nl) (nm) (nn) (no) (np) (nq) (nr) (ns) (nt) (nu) (nv) (nw) (nx) (ny) (nz) (oa) (ob) (oc) (od) (oe) (of) (og) (oh) (oi) (oj) (ok) (ol) (om) (on) (oo) (op) (oq) (or) (os) (ot) (ou) (ov) (ow) (ox) (oy) (oz) (pa) (pb) (pc) (pd) (pe) (pf) (pg) (ph) (pi) (pj) (pk) (pl) (pm) (pn) (po) (pp) (pq) (pr) (ps) (pt) (pu) (pv) (pw) (px) (py) (pz) (qa) (qb) (qc) (qd) (qe) (qf) (qg) (qh) (qi) (qj) (qk) (ql) (qm) (qn) (qo) (qp) (qq) (qr) (qs) (qt) (qu) (qv) (qw) (qx) (qy) (qz) (ra) (rb) (rc) (rd) (re) (rf) (rg) (rh) (ri) (rj) (rk) (rl) (rm) (rn) (ro) (rp) (rq) (rr) (rs) (rt) (ru) (rv) (rw) (rx) (ry) (rz) (sa) (sb) (sc) (sd) (se) (sf) (sg) (sh) (si) (sj) (sk) (sl) (sm) (sn) (so) (sp) (sq) (sr) (ss) (st) (su) (sv) (sw) (sx) (sy) (sz) (ta) (tb) (tc) (td) (te) (tf) (tg) (th) (ti) (tj) (tk) (tl) (tm) (tn) (to) (tp) (tq) (tr) (ts) (tt) (tu) (tv) (tw) (tx) (ty) (tz) (ua) (ub) (uc) (ud) (ue) (uf) (ug) (uh) (ui) (uj) (uk) (ul) (um) (un) (uo) (up) (uq) (ur) (us) (ut) (uu) (uv) (uw) (ux) (uy) (uz) (va) (vb) (vc) (vd) (ve) (vf) (vg) (vh) (vi) (vj) (vk) (vl) (vm) (vn) (vo) (vp) (vq) (vr) (vs) (vt) (vu) (vv) (vw) (vx) (vy) (vz) (wa) (wb) (wc) (wd) (we) (wf) (wg) (wh) (wi) (wj) (wk) (wl) (wm) (wn) (wo) (wp) (wq) (wr) (ws) (wt) (wu) (wv) (ww) (wx) (wy) (wz) (xa) (xb) (xc) (xd) (xe) (xf) (xg) (xh) (xi) (xj) (xk) (xl) (xm) (xn) (xo) (xp) (xq) (xr) (xs) (xt) (xu) (xv) (xw) (xx) (xy) (xz) (ya) (yb) (yc) (yd) (ye) (yf) (yg) (yh) (yi) (yj) (yk) (yl) (ym) (yn) (yo) (yp) (yq) (yr) (ys) (yt) (yu) (yv) (yw) (yx) (yy) (yz) (za) (zb) (zc) (zd) (ze) (zf) (zg) (zh) (zi) (zj) (zk) (zl) (zm) (zn) (zo) (zp) (zq) (zr) (zs) (zt) (zu) (zv) (zw) (zx) (zy) (zz)					

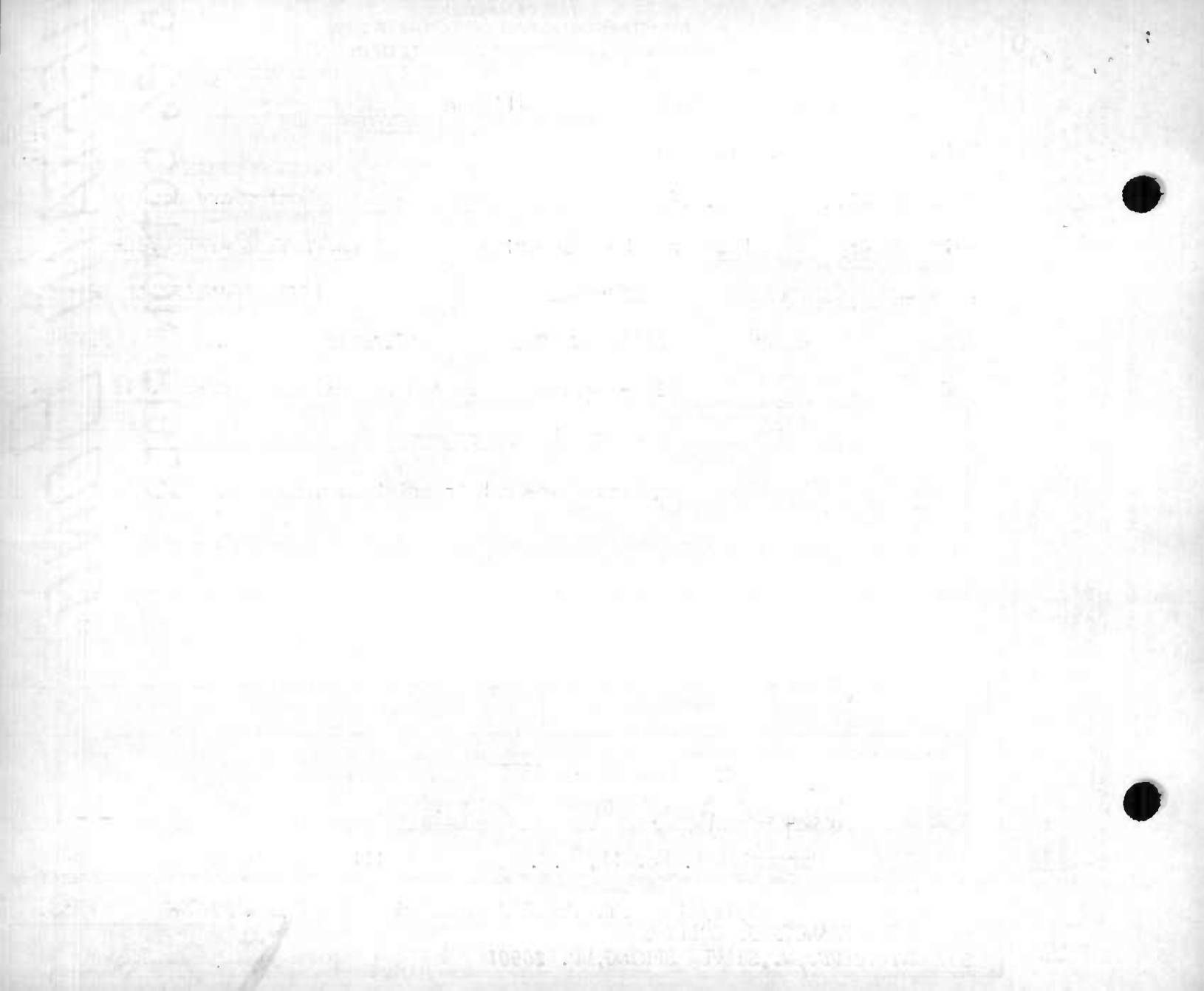
MEDICAL CERTIFICATION
COPIED + RELEASED



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY. PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE MEDICAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE RETURNED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.
1. DECEASED NAME (TYPE OR PRINT) John HENRY Callahan JR							2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> 8 6 1981		2b. HOUR 6:50 A.M.	
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR MAY 11, 1953	6. AGE (IN YEARS LAST BIRTHDAY) 28	IF UNDER 1 YR. MONTHS DAYS HOURS MIN	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD 8 7 1981		2d. HOUR 6:50 A.M.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MASSACHUSETTS		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County				
10. CITY OR TOWN OF DEATH Gaithersburg		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1908 Bramble Bush Drive				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CARPENTERS APPRENTICE		12b. KIND OF BUSINESS OR INDUSTRY		
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										
13a. STATE MARYLAND		13b. CITY OR TOWN MONTGOMERY		13c. CITY OR TOWN GAITHERSBURG		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 19816 BRAMBLEBUSH DRIVE		
14. FATHER'S NAME FIRST MIDDLE LAST JOHN HENRY CALLAHAN, SR.				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ELIZABETH R. FLYNN						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO		(IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO. 216-64-1178		17. INFORMANT JO ANN E. CALLAHAN		ADDRESS SAME AS 13 WIFE		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Subarachnoid Hemorrhage 4300 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) Ruptured Cerebral Arterial Aneurysm (c) _____ DUE TO, OR AS A CONSEQUENCE OF									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. a										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .										
ACTUAL SIGNATURE Margarita A. Korell			TITLE (SPECIFY) Assistant			MEDICAL EXAMINER		DATE SIGNED 8-7-81		
EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D.			ADDRESS 111 Penn Street							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 8/10/81		23c. NAME OF CEMETERY OR CREMATORY ST. PETER'S CEMETERY			23d. LOCATION CITY OR TOWN COUNTY STATE GREAT BARRINGTON MASS.			
24. FUNERAL DIRECTOR FRANCIS J. COLLINS						25a. DATE REC'D. BY REGISTRAR AUG 12 1981				
NAME 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901						25b. REGISTRAR'S SIGNATURE Francis J. Collins				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Registrar after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										
1- FOR STATE REGISTRAR										
CERTIFICATE OF DEATH										
REG. NO.										
1. DECEASED NAME (TYPE OR PRINT) Thomas C. Carlson					2a. DATE OF DEATH MONTH DAY YEAR August 25, 1981					2b. HOUR 7:08 pm
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR October 24, 1897		6. AGE (IN YEARS LAST BIRTHDAY) 83		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ohio		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.				
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Shady Grove Adventist Hosp.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Broker		12b. KIND OF BUSINESS OR INDUSTRY Real Estate		
13a. STATE Florida					13b. CITY OR TOWN Pinellas		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST Not Available					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Not Available					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. WW1		17. INFORMANT ADDRESS (# 13) Mrs. Dorothy B. Carlson (Same as item)						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										
PART I. DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a) 4360										
DUE TO, OR AS A CONSEQUENCE OF (b) Cardiac Failure										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. CUA										
DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from 8/25 , 19 81 , to 8/26 , 19 81 , that (I) (we) last saw the deceased alive on 8/25 , 19 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE R. Greger				DEGREE Covering for Director		22c. DATE SIGNED 8/26/81				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Ronald E. Greger, M.D.				22e. ADDRESS 12105 Darnestown Road Gaithersburg, Maryland						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial Removal		23b. DATE August 29, 1981		23c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE St. Petersburg Pinellas Fla.				
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey				25a. DATE REC'D. BY REGISTRAR AUG 31 1981		25b. REGISTRAR'S SIGNATURE [Signature]				
Homes, P.A. Bethesda, Maryland 20814										

Handwritten notes and signatures at the top of the page, including a signature that appears to be "J. H. [unclear]" and some illegible text.

Handwritten notes and signatures at the bottom of the page, including a signature that appears to be "J. H. [unclear]" and some illegible text.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
8 1 2 1 5 9 6 CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) CATHERINE C. CARTER					2a. DATE OF DEATH MONTH DAY YEAR 8-19-81 2b. HOUR 7:07P.M.				
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 12 07 19		6. AGE (IN YEARS LAST BIRTHDAY) 61 YRS		7. UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A. American		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Shaley Grove Adventist				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland					13b. COUNTY Montgomery		13c. CITY OR TOWN Dickerson		
14. FATHER'S NAME FIRST MIDDLE LAST George Washington Reed					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Liza Jane Gray				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. —		17. INFORMANT ADDRESS Mary Carter 19020 Wasche Road					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchogenic Carcinoma Lung 1629 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 months
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 1977, 19 to 8/19, 1981, that (I) (we) last saw the deceased alive on 8/19, 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE S. Withrow MD					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 8/19/81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SUSAN J. WITHROW					22e. ADDRESS 15 E Deer Park Dr, Gaithersburg Md.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 8/24/81		23c. NAME OF CEMETERY OR CREMATORY Moniacy		23d. LOCATION CITY OR TOWN COUNTY STATE Beallsville Montg. Md.		
24. FUNERAL DIRECTOR NAME W C Helt					ADDRESS Baltimore Md		25a. DATE REC'D. BY REGISTRAR AUG 26 1981		
					25b. REGISTRAR'S SIGNATURE Thane J. Martin				

MEDICAL CERTIFICATION



[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page. Some words like "Bull" and "AUG 24 1961" are visible at the bottom.]

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE FILES AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 21597	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) Anthony J. Caruso										2a. DATE KNOWN OF DEATH ESTIMATED Aug 20 1981	
3. SEX M		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR July 9 27 54		6. AGE (IN YEARS LAST BIRTHDAY) YEARS MONTHS DAYS 27 54		7c. DATE PRONOUNCED DEAD Aug 20 1981		7b. HOUR 8:25	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery	
10. CITY OR TOWN OF DEATH Olney				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Mont. General Hosp.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Teacher		12b. KIND OF BUSINESS OR INDUSTRY Mont. Co. Sch.	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE Md.		13b. COUNTY Mont.		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 219 Carter Rd			
14. FATHER'S NAME FIRST MIDDLE LAST John Caruso				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Catherine Gallo							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes				(IF YES, GIVE WAR OR DATES) WWII		16b. SOCIAL SECURITY NO. 123-20-5853		17. INFORMANT Wilma F. Caruso ADDRESS Same as items 13a-e			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Dis. 4291 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) Chronic Myocardial Dis. KRO. (c) None										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):											
19a. DATE OF OPERATION None				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE John S. Rogers						TITLE (SPECIFY) Dep			DATE SIGNED Aug 20 1981		
EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers						ADDRESS 1919 Seminary Rd. Silver Spring Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 8/24/81		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cem.				23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring Mont. Md.	
24. FUNERAL DIRECTOR NAME Tyson Wheeler Funeral Home, Inc. ADDRESS 1331 Rockville Pike Rockville, Maryland						25a. DATE REC'D. BY REGISTRAR AUG 25 1981		25b. REGISTRAR'S SIGNATURE Thomas J. Harris			

3.

New York

U.S.A.

Teacher

Wm. Co. 101

John

George

Catherine

John

Tom

101-101-101

Wm. Co. 101

101-101-101

John

Wm. Co. 101

Wm. Co. 101

Wm. Co. 101

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) NELLIE EVELYN CHAMBERLIN			2a. DATE OF DEATH MONTH DAY YEAR Aug. 26, 1981			2b. HOUR 9:58 A.M.			
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 05 23 15		6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.			
10. CITY OR TOWN OF DEATH MARYLAND		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOLY CROSS Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) BOOK STORE MANAGER		12b. KIND OF BUSINESS OR INDUSTRY MONT. COLLEGE	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD 13b. COUNTY Mtgy 13c. CITY OR TOWN Silver Spring					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 10501 Hayes Ave		
14. FATHER'S NAME FIRST MIDDLE LAST OTHA SNYDER					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MABEL LUCK				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 378 115 8007 49		17. INFORMANT ADDRESS DONALD R. CHAMBERLIN SAME AS 13 SON					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Respiratory Failure 1930 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Anaplastic CA of Thyroid (c) CA of Thyroid								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days 3 months	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) NO									
19a. DATE OF OPERATION 8/19/81		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Tracheostomy				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 1109 Spring St Silver Spring Md. 20910					
22a. I certify that (1) this hospital attended the deceased from 8/25 19 81 , to 8/26 19 81 , that (1) we last saw the deceased alive on 8/25 19 81 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (1) we (did) (did not) view the body after death.									
22b. SIGNATURE Peter B. Sherer				DEGREE MD				22c. DATE SIGNED 8/26/81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) PETER B. SHERER MD				22e. ADDRESS 1109 Spring St Silver Spring Md. 20910					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 8/28/81		23c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL		23d. LOCATION CITY OR TOWN COUNTY STATE ARLINGTON VIRGINIA			
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS				25a. DATE REC'D. BY REGISTRAR SEP 2 1981		25b. REGISTRAR'S SIGNATURE James J. [Signature]			
500 UNIV. BLVD. W., SILVER SPRING, MD. 20901									

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires, that the death certificate be executed within 24 hours after death. Part 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8	1	2	1	5	9	9			
FOR 1- STATE REGISTRAR										REG. NO.									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST HELEN E Chapin										2a. DATE OF DEATH MONTH DAY YEAR August 10, 1981				2b. HOUR 6:50 AM					
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Feb. 16, 1920		6. AGE (IN YEARS LAST BIRTHDAY) 61 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.									
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD.													
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SPEC. FACILITY, GIVE STREET ADDRESS) Rockville Nursing Home Rd				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Secretary		12b. KIND OF BUSINESS OR INDUSTRY Nat'l. Radio Inst											
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 713 Mapleton Drive	
14. FATHER'S NAME FIRST MIDDLE LAST George A. Elmore				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lillian Esther Brown				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 578 38 2535		17. INFORMANT ADDRESS Clarksville, Maryland Vincent K. Elmore 11446 Rowley Rd.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Progressive cerebellar degeneration</u> 3349 DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Hypertension</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE													
22a. I certify that (I) (this hospital) attended the deceased from 19 <u>52</u> to <u>8-10</u> 19 <u>81</u> , that (I) (we) last saw the deceased alive on <u>8-2</u> 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										22b. SIGNATURE Donald L Bucy		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8-10-81					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DONALD L Bucy / SN Jones				22e. ADDRESS 809 Veirs Mill Rd Rockville, Maryland															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE August 12 1981		23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory Alexandria Fairfax Virginia		23d. LOCATION CITY OR TOWN COUNTY STATE													
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY FUNERAL HOMES P/A 300 W. MONTGOMERY AVE., ROCKVILLE, MD. 20850				25a. DATE REC'D. BY REGISTRAR AUG 18 1981		25b. REGISTRAR'S SIGNATURE Name Jan [Signature]													

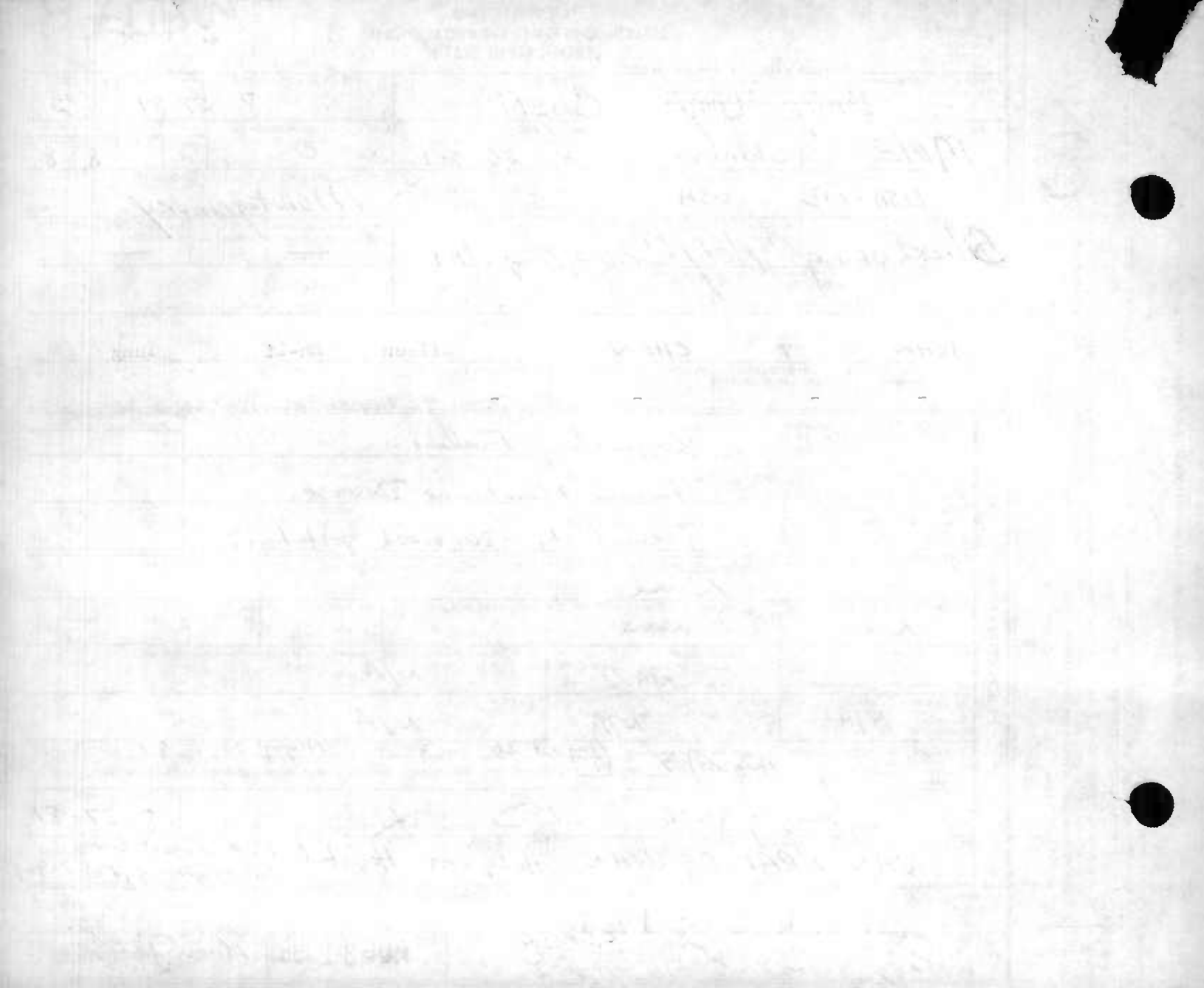


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8121600			
1. FOR STATE REGISTRAR WINSTON MICHAEL				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST BABY XXXXXXXX CHEN				2a. DATE OF DEATH MONTH DAY YEAR 8 27 81		2b. HOUR 6:15 AM	
3. SEX MALE		4. RACE Chinese		5. DATE OF BIRTH MONTH DAY YEAR 8 26 81		6. AGE (IN YEARS LAST BIRTHDAY) 0 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) USA-MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE Maryland				13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST JOHN T CHEN				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Eileen Eh-Li Tung			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO		17. INFORMANT ADDRESS John T. Chen-father-(same as 13c)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Hyaline Membrane Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Prematurity - 26 week gestation</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>None</u>							
19a. DATE OF OPERATION <u>None</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>None</u>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. NA 19 81		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) <u>N/A</u>			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> AT HOME <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <u>N/A</u>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <u>N/A</u>			
22a. I certify that (I) (this hospital) attended the deceased from <u>August 26</u> , 19 <u>81</u> , to <u>August 27</u> , 19 <u>81</u> , that (I) (we) last saw the deceased alive on <u>August 27</u> , 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>John V. Brakle</u>				DEGREE <u>MD</u>		22c. DATE SIGNED <u>8-27-81</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>VAN BRAKLE, JOHN</u>				22e. ADDRESS <u>Holy Cross Hospital 1500 Forest Glen Silver Spring, Md 20901</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Cremation</u>		23b. DATE <u>8-28-81</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Metropolitan</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Alexander, Alex. Va.</u>	
24. FUNERAL DIRECTOR NAME <u>Walter Humphrey Jr</u>				25. DATE RECEIVED BY REGISTRAR (SEE REGISTRAR'S SIGNATURE) <u>AUG 31 1981</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

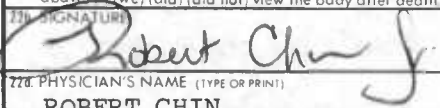

DHMH - 16 50M 1/81
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 2 1 6 0 1

1- FOR
STATE
REGISTRAR

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST IRENE RUTH CHERNOCK			2a DATE OF DEATH MONTH DAY YEAR AUG 13 81		2b HOUR 2319 M
3 SEX FEMALE	4 RACE CAUCS	5 DATE OF BIRTH MONTH DAY YEAR JUNE 13 1911		6 AGE (IN YEARS LAST BIRTHDAY) 70 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEBRASKA	7b CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.	
10 CITY OR TOWN OF DEATH BETHESDA	11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NATIONAL NAVAL MEDICAL CENTER		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE	12b KIND OF BUSINESS OR INDUSTRY N/A	
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE VIRGINIA	13b COUNTY FAIRFAX	13c CITY OR TOWN VIENNA	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e STREET ADDRESS 2571 PLUM TREE COURT	
14 FATHER'S NAME FIRST MIDDLE LAST ABRAHAM HIRSCH		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST IDA FRANKLIN			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b SOCIAL SECURITY NO. 231-70-6770		17 INFORMANT ADDRESS HARRY J. CHERNOCK PO BOX 39 VIENNA, VA 2571 PLUM TREE COURT	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) FULMINANT HEPATITIS 0709 DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ✓					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b SIGNATURE 		DEGREE MD		22c DATE SIGNED 14 Aug 81	
22d PHYSICIAN'S NAME (TYPE OR PRINT) ROBERT CHIN		22e ADDRESS NATIONAL NAVAL MEDICAL CENTER			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b DATE AUG 16, 1981	23c NAME OF CEMETERY OR CREMATORY KING DAVID MEMORIAL		23d LOCATION CITY OR TOWN COUNTY STATE FALLS-CHURCH	
24 FUNERAL DIRECTOR NAME DANZANSKY-GOLDBERG		ADDRESS 1170 Rockville Pike ROCKVILLE, MD		DATE REC'D. BY REGISTRAR 25b REGISTRAR'S SIGNATURE AUG 17 1981 	

MEDICAL CERTIFICATION



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

81 21602

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR					
FIRST	MIDDLE	LAST	MONTH	DAY	YEAR	MONTH		DAY			
Mary Elizabeth Chesser			8 - 3 - 81			3:05A _M					
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR			
Female		White		MONTH DAY YEAR		82		MONTHS DAYS HOURS MIN			
Nov. 29 1898		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		10. IF UNDER 24 HRS			
U. S. A.		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		Montgomery		MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION		12a. USUAL OCCUPATION		12b. KIND OF BUSINESS OR INDUSTRY					
Kensington		Circle Manor Nursing Home		Housewife							
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?		
Md.			Montgomery			Sil. Spr.			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16. STREET ADDRESS					
Abraham			Litton			Effie			Coffman		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS		
No			578-14-7694A			Edith L. Lampe			711 McNeil Lane Sil. Spr., Md.		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

4149

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

Cardiac arrhythmia

Coronary heart disease

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

2 to 2 1/2

years

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

chronic organic brain syndrome

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?YES ☐ NO ☐YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED
WHILE ☐ NOT WHILE ☐
AT WORK AT WORK

21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION

CITY OR TOWN

COUNTY

STATE

22a. I certify that (if this hospital) attended the deceased from March 5, 1976, to Aug. 3, 1981, that (I) (we) last
saw the deceased alive on July 13, 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above. (I) (we) did (did not) view the body after death.

22b. SIGNATURE

DEGREE

22c. DATE SIGNED

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

22e. ADDRESS

ATTENDING ☒ MEDICAL ☐ STAFF
- PHYSICIAN DIRECTOR PHYSICIAN

8/3/81

23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)

23b. DATE

23c. NAME OF CEMETERY OR CREMATORY

23d. LOCATION

COUNTY

STATE

Burial

8/5/81

Burtonsville Union Cem.

Burtonsville, Md.

24. FUNERAL DIRECTOR
NAME

ADDRESS

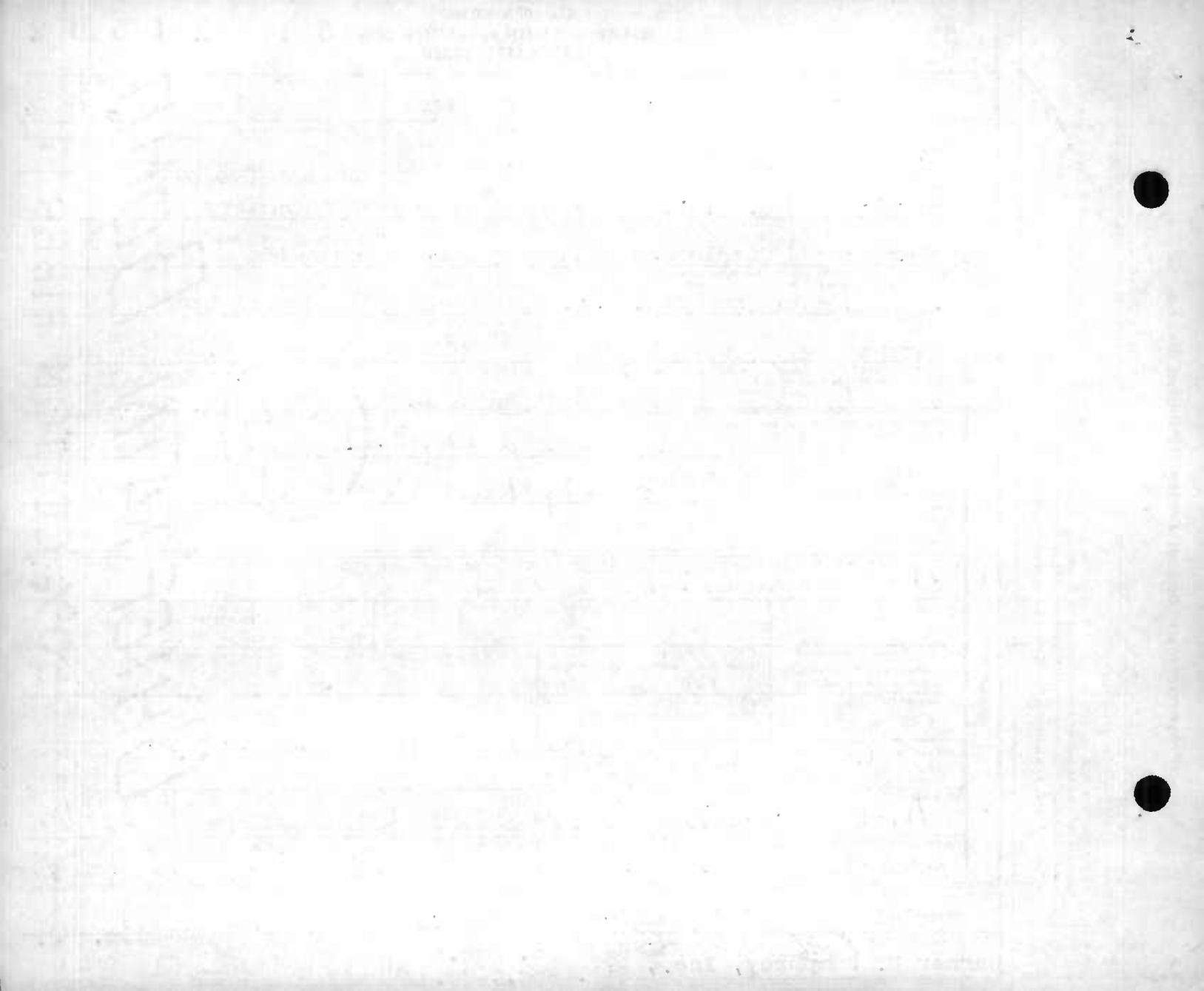
25a. DATE REC'D. BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

Warner E. Pumphrey, Inc., Sil. Spr., Md.

AUG 5 1981

R. J. [Signature]



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
1. STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 2 1 6 0 3

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Mabel Todd Cole			2a. DATE OF DEATH MONTH DAY YEAR 8-28-81			2b. HOUR 5:00 PM				
3 SEX FEMALE		4 RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR Nov. 28 1894		6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) SOUTH CAROLINA		7b. CITIZEN OF WHAT COUNTRY? U.S.A		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.				
10. CITY OR TOWN OF DEATH SILVER SPRING		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1512 GRACE CHURCH ROAD				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEMAKER		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD			13b. COUNTY MONT.		13c. CITY OR TOWN SILVER SPRING		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1512 GRACE CHURCH RD	

14. FATHER'S NAME FIRST MIDDLE LAST Adam SUMMER TODD			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ellen Archer.		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO 220-469587		17. INFORMANT ADDRESS LELAND A. COLE 1512 GRACE CHURCH RD S.S.MD	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Cerebral Respiratory Arrest		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
4392 } DUE TO, OR AS A CONSEQUENCE OF (b) Cerebrovascular Accident		years.	
DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerotic Cardiovascular Disease		years.	

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22. I certify that (I) this hospital attended the deceased from August 19 1981 to August 28 1981 , that (II) (we) last saw the deceased alive on August 19 1981 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22a. SIGNATURE Benjamin Furman, MD DEGREE				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8-28-81	
22b. PHYSICIAN'S NAME (TYPE OR PRINT) Benjamin Furman, MD				22d. ADDRESS 3720 Fairview Ave. Newald			

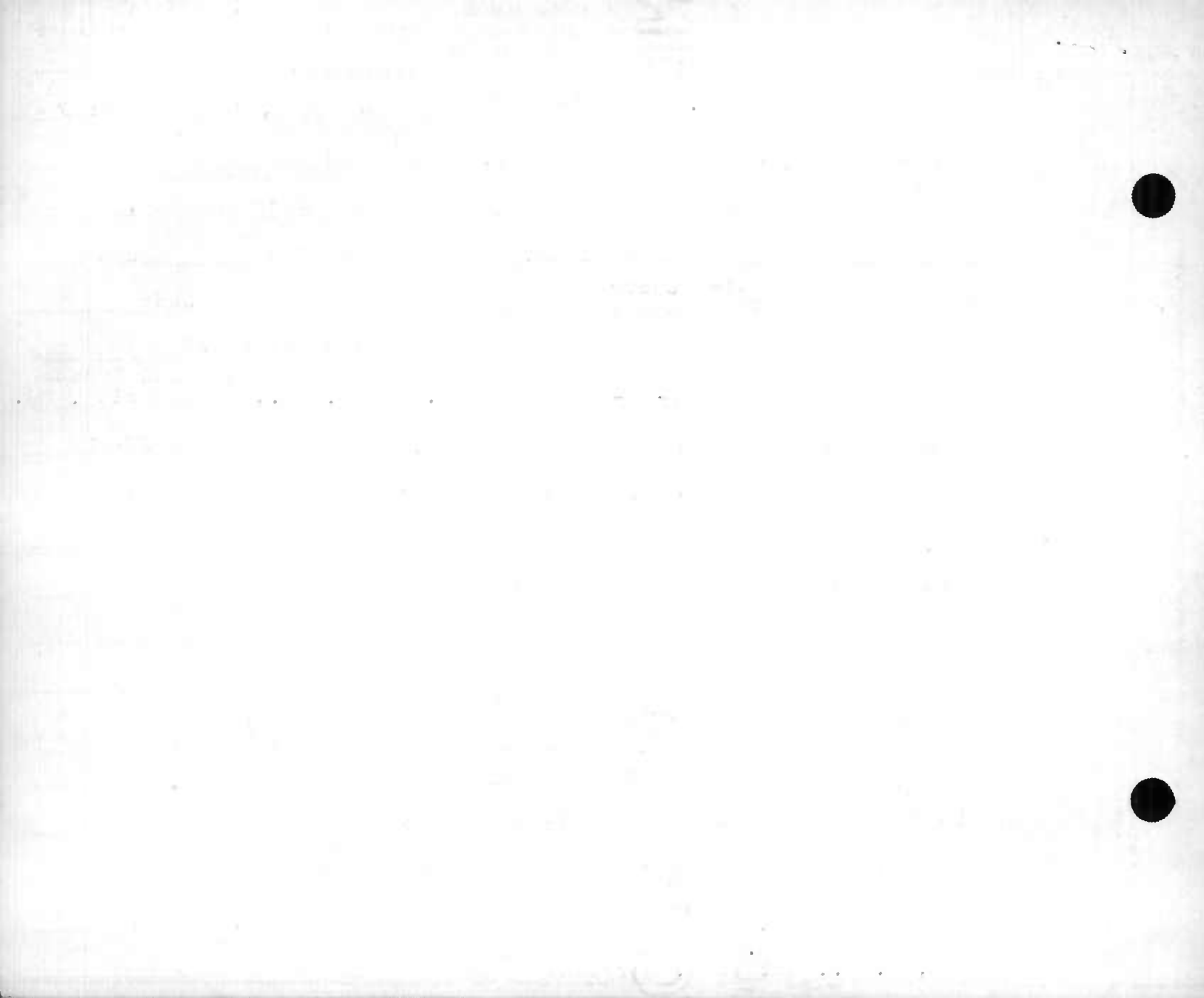
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) ENTOMBMENT		23b. DATE SEPT. 1. 1981		23c. NAME OF CEMETERY OR CREMATORY Fall Creek Mausoleum		23d. LOCATION CITY OR TOWN COUNTY STATE Bethesda P.G. MD	
24. FUNERAL DIRECTOR NAME Takoma Funeral Home ADDRESS 254 Carroll Rd N.C.D.C.				25a. DATE REC'D. BY REGISTRAR SEP 3 1981		25b. REGISTRAR'S SIGNATURE James J. ...	

2

TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8121604							
1. FOR STATE REGISTRAR			REG. NO.														
1 DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a DATE OF DEATH, MONTH DAY YEAR			2b HOUR A		
Edna			C.			Conradi			August 3, 1981			5:25 M					
3 SEX			4 RACE			5 DATE OF BIRTH MONTH DAY YEAR			6 AGE (IN YEARS LAST BIRTHDAY) YRS			7 IF UNDER 1 YEAR MONTHS DAYS			8 IF UNDER 24 HRS HOURS MIN.		
Female			Caucasian			April 17, 1888			93								
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b CITIZEN OF WHAT COUNTRY?			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH								
Maryland			United States						Montgomery County, MD.								
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b KIND OF BUSINESS OR INDUSTRY								
Silver Spring			Sylvan Manor Nursing Home			Housewife			Home								
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13a STATE			13b COUNTY			13c CITY OR TOWN			13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e STREET ADDRESS		
Maryland			Montgomery			Chase						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			4309 Bradley Lane		
14 FATHER'S NAME FIRST MIDDLE LAST			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST														
John			Hilgerman			(unavailable)											
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17 INFORMANT			ADDRESS								
No			577-84-4697			George H. Riley, Jr.			9506 2nd Avenue, Silver Spring, Md.								
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrhythmia</u> 4149 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary heart disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Instant</u> <u>year</u>																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>chronic organic brain syndrome</u>																	
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>								
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)											
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET CITY OR TOWN COUNTY STATE											
22a I certify that (1) this hospital attended the deceased from <u>6/12</u> 19 <u>81</u> , to <u>8/3</u> 19 <u>81</u> , that (1) (we) lost saw the deceased <u>above</u> <u>6/23</u> 19 <u>81</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above; (2) (we) did not view the body after death.																	
22b SIGNATURE <u>Martin C. Shargel</u>			DEGREE <u>M.D.</u>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c DATE SIGNED <u>8/3/81</u>								
22d PHYSICIAN'S NAME (TYPE OR PRINT) <u>MARTIN C. SHARGEL</u>			22e ADDRESS <u>3720 FARLEIGH Ave</u> <u>Kenneth, Md 20895</u>														
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>			23b DATE <u>August 5, 1981</u>			23c NAME OF CEMETERY OR CREMATORY <u>Arlington National Cemetery</u>			23d LOCATION CITY OR TOWN COUNTY STATE <u>Arlington Virginia</u>								
24 FUNERAL DIRECTOR NAME <u>ROBERT A. PUMPHREY FUNERAL HOMES, P. A., Bethesda, Maryland</u>			25a D. BY REGISTRAR			25b REGISTRAR'S SIGNATURE <u>AUG 1981</u>			25c REGISTRAR'S SIGNATURE <u>[Signature]</u>								



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8121605	
1. FOR STATE REGISTRAR					REG. NO.						
1. DECEASED NAME (TYPE OR PRINT) Mary L. COOPER					2a. DATE OF DEATH MONTH DAY YEAR August 24 1981				2b. HOUR 6:08A M		
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Dec. 3 1893		6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		7. IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Italy		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.					
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) National Naval Medical Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY None			
13a. STATE D. C.		13b. COUNTY none		13c. CITY OR TOWN Washington		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 725 24th Street, N.W.			
14. FATHER'S NAME FIRST MIDDLE LAST Giuseppe Giuliani					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Leopolda (unavailable)						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 577 84 4249		17. INFORMANT ADDRESS Joseph A. Cooper 4319 Albemarle St. N.W. Washington, D.C.					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>RESPIRATORY FAILURE</u> 4280 DUE TO, OR AS A CONSEQUENCE OF (b) <u>CHRONIC DECOMPENSATED CONGESTIVE HEART FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>CHRONIC GASTROINTESTINAL BLEEDING</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (s) (this hospital) attended the deceased from <u>August 11</u> 19 <u>81</u> to <u>August 24</u> 19 <u>81</u> that (we) last saw the deceased alive on <u>August 24</u> 19 <u>81</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) did (s) (we) view the body after death.											
22b. SIGNATURE <u>Edward M. Lynch</u>				DEGREE M.D.				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED Aug. 26 1981	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Edward M. Lynch, M.D.				22e. ADDRESS National Naval Medical Center, Bethesda, Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Sept. 1, 81		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION CITY OR TOWN COUNTY STATE Arlington, Arlington Va					
24. FUNERAL DIRECTOR <u>DeVol Funeral Home</u>				ADDRESS Washington, D.C.		25a. DATE BY REGISTRATION SEP 2 1981		25b. SIGNATURE <u>John J. DeVol</u>			

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ALL INFORMATION CONTAINED
HEREIN IS UNCLASSIFIED
DATE 11-11-01 BY 60322 UCBAW/STP

ALL INFORMATION CONTAINED
HEREIN IS UNCLASSIFIED
DATE 11-11-01 BY 60322 UCBAW/STP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 7 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8 1 2 1 6 0 6	
1. DECEASED NAME (TYPE OR PRINT) GRACE J. CORCORAN						2a. DATE OF DEATH MONTH DAY YEAR 8-3-81		2b. HOUR 12²⁵ PM			
3. SEX FEMALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR AUG 29, 1888		6. AGE (IN YEARS LAST BIRTHDAY) 92 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VIRGINIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.					
10. CITY OR TOWN OF DEATH KENSINGTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) KENSINGTON GARDENS NURSING HOME				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE MARYLAND		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN WHEATON		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 14210 GRAND PRE ROAD			
14. FATHER'S NAME FIRST MIDDLE LAST JAMES HOPE				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST EOLINE HOPE							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 218-54-6569		17. INFORMANT GRACE M. ORR		ADDRESS SAME AS 13		DAUGHTER			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRO-VASCULAR THROMBOSIS 4380 DUE TO, OR AS A CONSEQUENCE OF (b) PREVIOUS CVA DUE TO, OR AS A CONSEQUENCE OF (c) ARTERIO SCLEROSIS, GEN + CEREBRAL APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 17 DAYS 1 YR 9 MO 2 YR.											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: ARTERIO SCLEROTIC HEART DIS. & ATRIAL FIBRILLATION											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from OCT 1974 to AUG 3, 1981 , that (we) last saw the deceased alive on AUG 3, 1981 , and that in (my) my opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Leo M. Curtis				DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8-3-81			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) LEO M. CURTIS				22e. ADDRESS 8218 WISCONSIN AVE., BETHESDA, MARYLAND							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 8/6/81		23c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE BRENTWOOD PRT GEO MD.					
24. FUNERAL DIRECTOR NAME ADDRESS FRANCIS J. COLLINS 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901				25a. DATE REC'D. BY REGISTRAR AUG 7 1981		25b. REGISTRAR'S SIGNATURE James J. Smith					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

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FOR 1- STATE REGISTRAR		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) Edward J. COSTELLO, JR.		2a. DATE OF DEATH MONTH DAY YEAR August 5 1981	
3 SEX Male		2b. HOUR 7:20A ^M	
4 RACE Caucasian		5 DATE OF BIRTH MONTH DAY YEAR Aug. 7 1899	
6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 74 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? USA	
8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD.	
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) National Naval Medical Center	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) U. S. Navy		12b. KIND OF BUSINESS OR INDUSTRY Military	
13a. STATE Maryland		13b. COUNTY Montgomery	
13c. CITY OR TOWN Bethesda		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS 5318 McKinley Street		14 FATHER'S NAME FIRST MIDDLE LAST Edward J. Costello	
15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Myrtle A. Palmer		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES NO	
16b. SOCIAL SECURITY NO. 1936-63		16c. ADDRESS Garland, Texas	
17 INFORMANT Edward J. Costello		18. DATE OF OPERATION 1981	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) SEPSIS + ACUTE BLEEDING FROM SMALL INFERIOR MESENTERIC ARTERY DUE TO, OR AS A CONSEQUENCE OF (b) 2500 gm Blood Clot DUE TO, OR AS A CONSEQUENCE OF (c) Abscess formation in Right Lower Quadrant		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21a. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21b. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)	
22a. I certify that (I) (this hospital) attended the deceased from July 7 1981 to August 5 1981, that (I) (we) lost above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE GM DAVIS, M.D.	
22c. DATE SIGNED Aug. 5 1981		22d. ADDRESS National Naval Medical Center, Bethesda, Md	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE August 10, 1981	
23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION CITY OR TOWN COUNTY STATE Arlington Arlington Va.	
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY FUNERAL HOMES, P.A., BETHESDA, MARYLAND		25a. DATE RECEIVED BY REGISTRAR AUG 10 1981	

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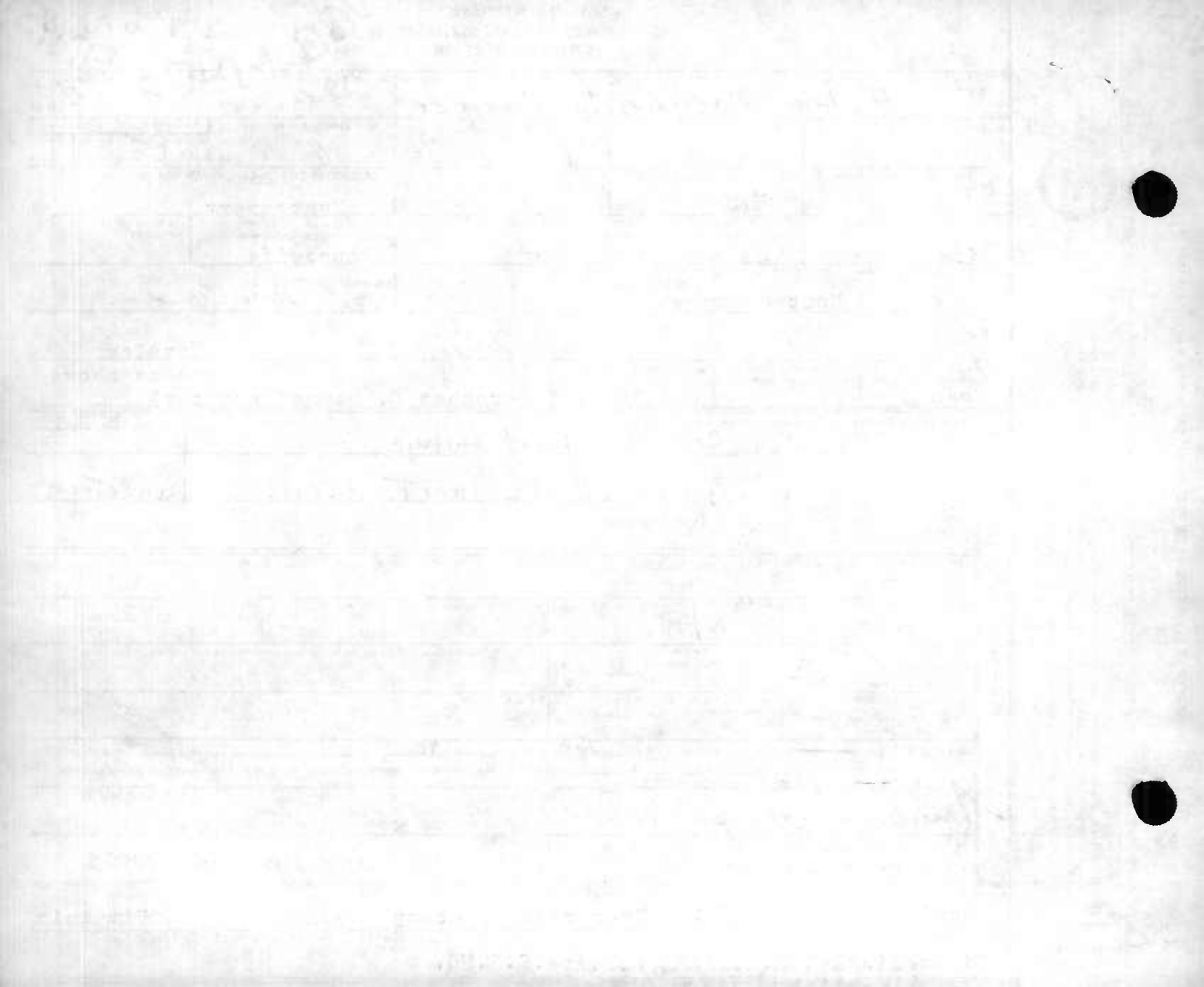
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health officer after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

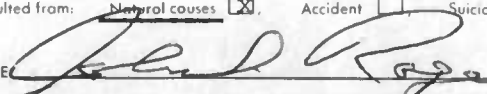

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 1 2 1 5 0 8			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <i>Helene Marguerite Cregier</i>				2a. DATE OF DEATH MONTH DAY YEAR <i>8/7/81</i>			
3. SEX <i>F</i>		4. RACE <i>W</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>8 10 93</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>87</i> YRS. MONTHS DAYS <i>11 27</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>VA.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery</i> MD.	
10. CITY OR TOWN OF DEATH <i>Takoma Park -</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Washington Adventist.</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <i>md.</i>		13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Takoma Park</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>James C. McClellan</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Margaret Kessler (Dec.)</i>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <i>None</i>			
16a. SOCIAL SECURITY NO. <i>215 50 8866</i>		17. INFORMANT <i>Dorothea C. Demma (Daughter)</i>		ADDRESS <i>Same as above</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Congestive heart failure</i> <i>4/140</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <i>Arteriosclerotic heart disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>undetermined</i>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION <i>N/A</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>N/A</i>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <input checked="" type="checkbox"/> (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the hospital) attended the deceased from <i>Jan</i> , 19 <i>70</i> , to <i>Jan</i> , 19 <i>81</i> , that (I) (we) lost saw the deceased alive on <i>Jan</i> , 19 <i>81</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.							
22b. SIGNATURE <i>William F. Simpson, MD</i>				DEGREE <i>MD</i>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>William F. Simpson, MD</i>				22e. ADDRESS <i>8106 N.H. Ave. S.W. 8th Fl. N.H. 20903</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>8/11/81</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Evergreen Cemetery</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Roanoke 2nd Virginia</i>	
24. FUNERAL DIRECTOR NAME ADDRESS <i>Hines/Rinaldi F.H. 11800 N.H. Ave. S.S. Md.</i>				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGES 1, 2, AND 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 21609	
1. DECEASED NAME (TYPE OR PRINT) Elverne R. Crisp						2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> 8-29, 19 81		2b. HOUR 11:25			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Jan. 14, 1928		6. AGE (IN YEARS LAST BIRTHDAY) 53 YRS.		IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina			7b. CITIZEN OF WHAT COUNTRY? United States			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County			
10. CITY OR TOWN OF DEATH Rockville			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4725 Wyaconda Road			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) School Teacher		12b. KIND OF BUSINESS OR INDUSTRY Education			
13a. STATE Maryland			13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET ADDRESS 4725 Wyaconda Road		
14. FATHER'S NAME FIRST MIDDLE LAST Roy S. Redding			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Minnie Hartgrove								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 246-42-4348			17. INFORMANT ADDRESS Sandra K. Crisp (Same as 13e)					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial disease DUE TO, OR AS A CONSEQUENCE OF (b) chronic myocardial disease. DUE TO, OR AS A CONSEQUENCE OF (c) 									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). None											
19a. DATE OF OPERATION None			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) None						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE 			TITLE (SPECIFY) Deputy			MEDICAL EXAMINER			DATE SIGNED 8/31/81		
EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers, M.D.			ADDRESS 1919 Seminary Road Silver Spring, Montgomery, Md.								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 1981		23c. NAME OF CEMETERY OR CREMATORY Parklawn Memorial Park			23d. LOCATION CITY OR TOWN COUNTY STATE Rockville Montgomery Maryland			
24. FUNERAL DIRECTOR NAME ROBERT A. PUMPHREY			ADDRESS 300 WEST MONTGOMERY AVE., ROCKVILLE, MD. 20850			25a. DATE REC'D. BY REGISTRAR SEP 4 1981		25b. REGISTRAR'S SIGNATURE 			





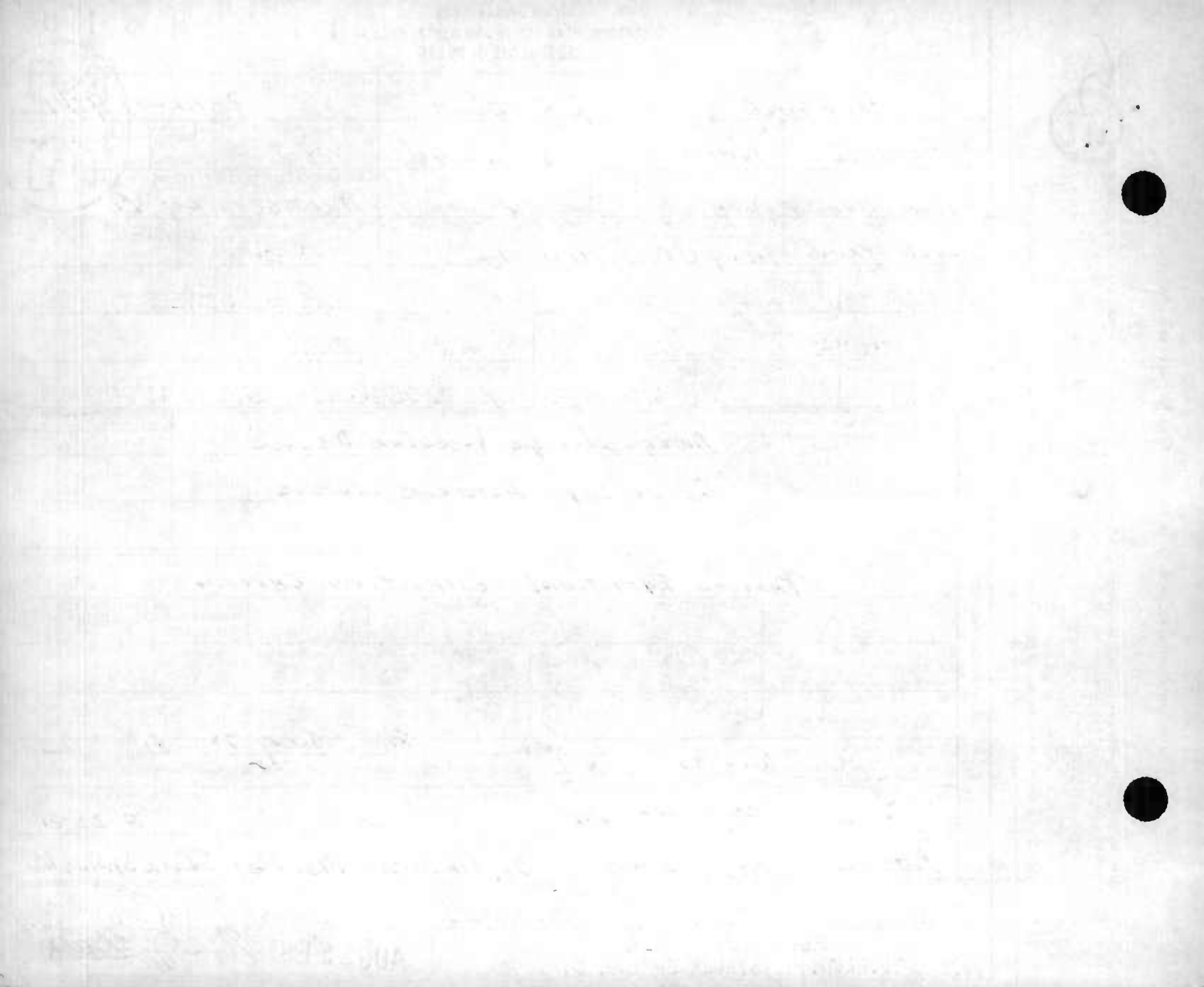
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8	1	2	1	6	1	0
1. FOR STATE REGISTRAR										REG. NO.						
1. DECEASED NAME (TYPE OR PRINT) ADELINE A. CRIVELLA										2a. DATE OF DEATH MONTH DAY YEAR 8-22-81				2b. HOUR 9:47 P		
3. SEX FEMALE			4. RACE WHITE			5. DATE OF BIRTH MONTH DAY YEAR 6-4-96			6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS.			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENNSYLVANIA			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY CO. MD.							
10. CITY OR TOWN OF DEATH SILVER SPRING			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOLY CROSS HOSPITAL							12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) HOUSEWIFE			12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE MARYLAND			13b. COUNTY MONTGOMERY			13c. CITY OR TOWN WHEATON			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 2512 MASON STREET					
14. FATHER'S NAME FIRST MIDDLE LAST NICHOLAS FERA					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ANNA MARIE											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 577-22-0474			17. INFORMANT ROSE M. DiFILIPPO					ADDRESS SAME AS 13 DAUGHTER					
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4409 ARTERIOSCLEROTIC VASCULAR DISEASE DUE TO, OR AS A CONSEQUENCE OF (b) GENERALIZED ARTERIOSCLEROSIS DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) PARTIAL INTESTINAL OBSTRUCTION, CHRONIC										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)										
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE										
22a. I certify that (I) (this hospital) attended the deceased from Jan 81, to Aug 22, 1981, that (I) (most) saw the deceased alive on Aug 22, 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (a) we (did) (did not) view the body after death.										22c. DATE SIGNED 8-23-81						
22b. SIGNATURE Bernard A. Fitzgerald MD			DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>													
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BERNARD A. FITZGERALD					22e. ADDRESS 217 UNIVERSITY BLVD EAST SILVER SPRING MD											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 8/26/81			23c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN			23d. LOCATION CITY OR TOWN COUNTY STATE BRENTWOOD PRI GEO MD							
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS					25a. DATE REC'D. BY REGISTRAR AUG 25 1981					25b. REGISTRAR'S SIGNATURE [Signature]						
500 UNIV. BLVD., W., SILVER SPRING, MD. 20901																

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death. Page 3 may be retained by the hospital or attending physician.

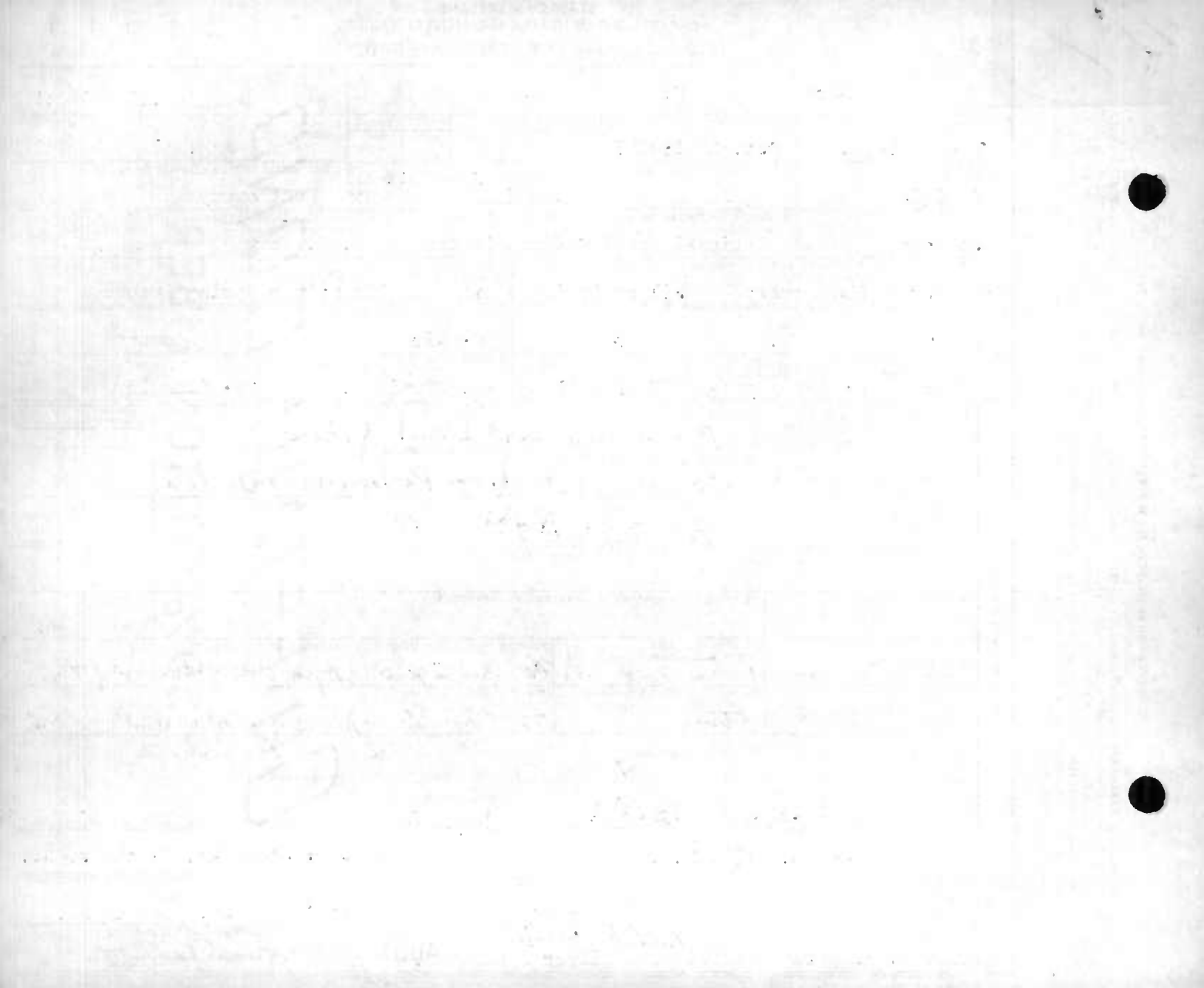
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-1. RETAIN PAGE 5 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED. WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 21611	
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) Jack CULP						2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR Aug. 17 19 81		2b. HOUR 2:18P	
3. SEX Male		4. RACE Cauc.		5. DATE OF BIRTH MONTH DAY YEAR Oct. 20 1907		6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN		2c. DATE PRONOUNCED DEAD Aug. 17 19 81	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		XXXXXXXXXX DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD					
10. CITY OR TOWN OF DEATH Bethesda,		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) National Naval Medical Center						12. USUAL OCCUPATION, TYPE OF WORK Photographer U. S. Navy		12b. KIND OF BUSINESS OR INDUSTRY US Navy	
13a. STATE Maryland		13b. CITY OR TOWN Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET ADDRESS 729 Silver Spring Avenue			
14. FATHER'S NAME FIRST Lawson		MIDDLE B.		LAST Culp		15. MOTHER'S MAIDEN NAME FIRST Jennie		MIDDLE Stewart		LAST	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes		(IF YES, GIVE SERVICE) Korean Conflict		16b. SOCIAL SECURITY NO. 577 05 9897		17. INFORMANT (mother) Mrs. Jennie S. Culp (See item 13)		ADDRESS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia. Left Lower Lobe - DUE TO, OR AS A CONSEQUENCE OF (b) Chronic Obstructive Pulmonary Disease. DUE TO, OR AS A CONSEQUENCE OF (c) Fracture Right H.I.P. Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR 8-8 MONTH DAY YEAR 19 81		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Knocked to ground by car door getting out of Taxi.					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Street		21f. LOCATION STREET 729 Silver Spring Ave. CITY OR TOWN Silver Spring COUNTY Mont. STATE Md					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE John G. Ball				TITLE (SPECIFY) Deputy				DATE SIGNED Aug. 17, 1981			
EXAMINER'S NAME (TYPE OR PRINT) John G. Ball, M.D.				ADDRESS 7936 Old Georgetown Rd. Bethesda, Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 8-20-1981		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln		23d. LOCATION CITY OR TOWN Brentwood Pr. George COUNTY Md. STATE			
24. FUNERAL DIRECTOR NAME Warner E. Pumphrey				ADDRESS Funeral Home Silver Spring				25a. DATE REC'D. BY REGISTRAR AUG 24 1981 REGISTRAR'S SIGNATURE James J. [Signature]			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death, with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 1 2 1 6 1 2			
1. FOR STATE REGISTRAR				CERTIFICATE OF DEATH			
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH			
DR. WILLIAM DWIGHT CURTIS				August 9, 1981			
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH June 14, 1905		6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Missouri		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.	
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Dentist		12b. KIND OF BUSINESS OR INDUSTRY Orthodontic	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13d. INSIDE CITY LIMITS?			
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Bethesda		13e. STREET ADDRESS 5408 Moorland Lane	
14. FATHER'S NAME FIRST MIDDLE LAST Winterton C. Curtis				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Marion Hitchcock			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 579-52-6193		17. INFORMANT ADDRESS Caroline C. Bloom 02668 241 Maple St. West Barnstable, Mass.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> 4100 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cronary Atherosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Generalized Atherosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Days</u> <u>years</u> <u>years</u>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>stroke, Hypertension, Paralytic Poliomyelitis</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) P.M. 19		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>Aug 2</u> , 19 <u>81</u> , to <u>Aug 9</u> , 19 <u>81</u> , that (I) (we) last saw the deceased alive on <u>Aug 9</u> , 19 <u>81</u> , and that in (my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above. (I) (we) <u>(did)</u> (did not) view the body after death.							
22b. SIGNATURE <u>Harris M Kenner</u>				DEGREE <u>MD</u>		22c. DATE SIGNED <u>8/10/81</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Harris M Kenner, M.D.				22e. ADDRESS 10401 Old Georgetown Rd Bethesda, MD. 20014			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE August 10, 1981		23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crem.		23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria, Virginia	
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Homes, P.A. Bethesda, Maryland				25. DATE REG'D. BY REGISTRAR AUG 13 1981			

[Faint, mostly illegible text, possibly bleed-through from the reverse side of the page. Some words like "UNITED STATES" and "DEPARTMENT OF" are faintly visible.]

10-01-01
 10-01-01

JAMES A. KENNEDY, JR.

[Faint text at the bottom of the page, including what appears to be a signature and some administrative markings.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 1/81
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) Lewis Edward Darling II					2a. DATE OF DEATH MONTH 8 DAY 03 YEAR 81 7b. HOUR 9:05 ^{a.}				
3. SEX male		4. RACE white		5. DATE OF BIRTH MONTH 9 DAY 3 YEAR 18		6. AGE (IN YEARS LAST BIRTHDAY) 62		7. IF UNDER 1 YEAR MONTHS 0 DAYS 0 HOURS 0 MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash. D.C.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery ^{MD}			
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Shady Grove Adventist Hosp.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) retired Mont. Co. Officer		12b. KIND OF BUSINESS OR INDUSTRY Correctional	
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME FIRST Lewis MIDDLE E. LAST Darling					15. MOTHER'S MAIDEN NAME FIRST Elizabeth MIDDLE Caroline LAST Damm				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes		16b. SOCIAL SECURITY NO. WW 11		17. INFORMANT ADDRESS Lois L. Darling same as 13c					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Primary Caecomy of Intestine 4254 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Chronic obstructive Pulmonary Emphysema									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			19c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		19d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (SEE EITHER, NOTIFY MEDICAL EXAMINER)		20b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)					
21a. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21c. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) (the deceased ^{physician} attended the deceased from 5/1/64 to 8/3/81 , that (1) the ^{deceased} last saw the deceased alive on 8/3/81 , 19 81 , and that in (my) my ^{my} opinion death occurred on the date and hour and from the causes stated above (1) the ^{the} deceased viewed the body after death.									
22b. SIGNATURE Robert C. Macon		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 8/3/81		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert C. Macon				22e. ADDRESS 809 Viers Mill Rd. Rockville, Maryland					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 8/4/81		23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crem.		23d. LOCATION CITY OR TOWN Alexandria COUNTY Virginia STATE			
24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home, Inc. 1331 Rockville Pike Rockville, Md. 20852				25a. DATE REC'D BY REGISTRAR AUG 10 1981 25b. REGISTRAR'S SIGNATURE James J. [Signature]					

1551 Rockville Pike - Rockville, Md. 20852
 Vason Greeter Funeral Home, Inc.
 8/4/61 Metropolitan Crem. Alexandria Virginia

Robert E. Mason 809 Vienna Mill Rd. Rockville, Maryland

[Faint handwritten notes and signatures]

[Faint handwritten notes and signatures]

259-01-2196 lots D. Darling same as 156
 8/4/61

Lewis 8. Darling Elizabeth Caroline
 Maryland Montgomery Rockville x 1101 Rock Road Rockville Md.
 Shady Grove Avenue at Mont. D. C. Office

Mrs. E.C. USA
 white 3 18 62
 8/4/61

Lewis Richard 8/4/61

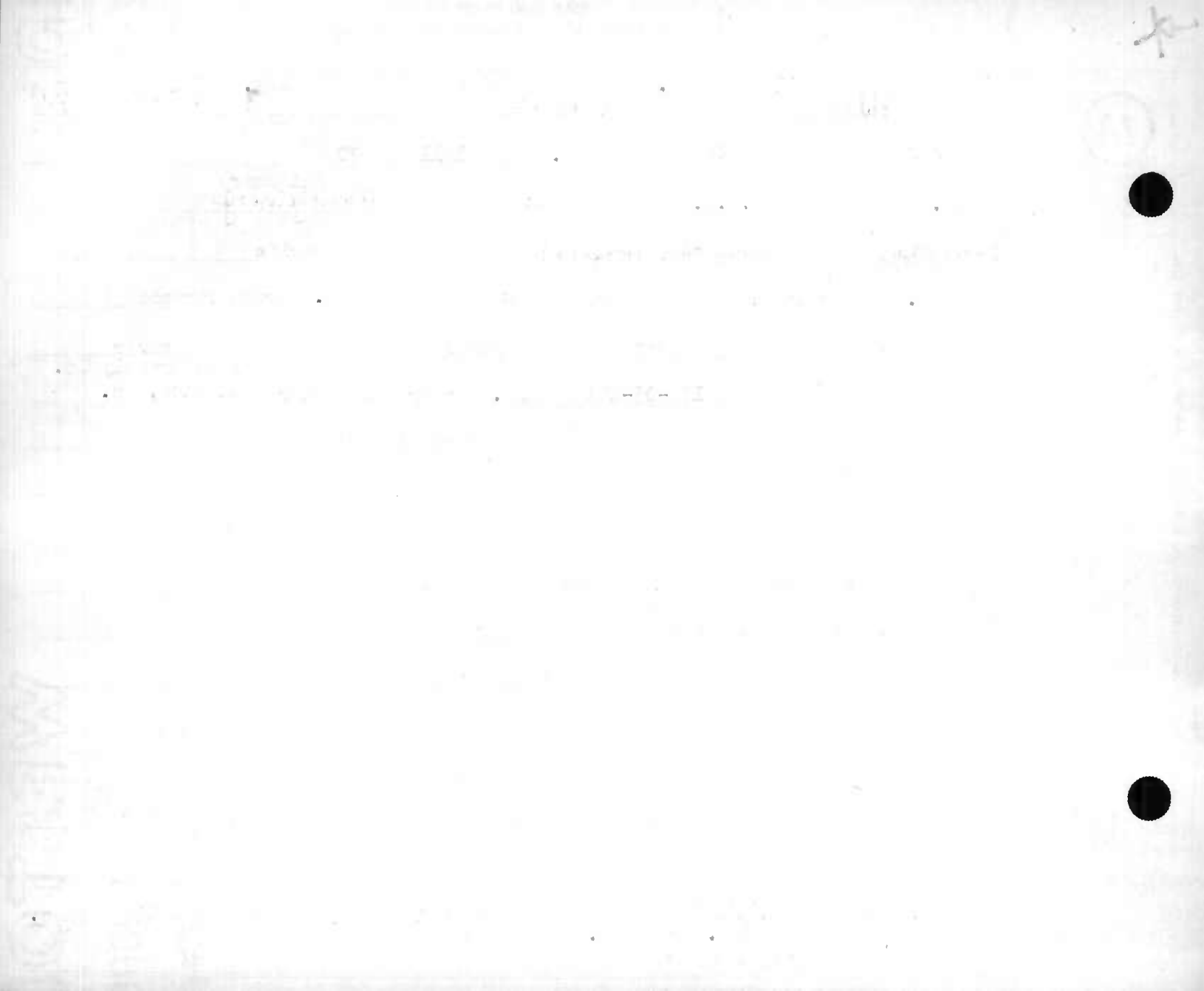
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If it is not, it must be re-signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 1 2 1 6 1 4	
1. FOR STATE REGISTRAR				REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) Hilda M. Davies			2a. DATE OF DEATH Aug 30 1981 8:15 PM		
3. SEX Female			4. RACE White		
5. DATE OF BIRTH Jan. 2 1911			6. AGE (IN YEARS LAST BIRTHDAY) 70		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penna.			7b. CITIZEN OF WHAT COUNTRY? U.S.A.		
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.		
10. CITY OR TOWN OF DEATH Bethesda			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife			12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Penna.			13b. COUNTY Franklin		
13c. CITY OR TOWN Waynesboro			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
13e. STREET ADDRESS 50 Mt. Vernon Terrace			14. FATHER'S NAME William		
15. MOTHER'S MAIDEN NAME Annie			16. BEAVER		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 173-03-1146D		
17. INFORMANT Mrs. Richard Forrester			ADDRESS 3804 Greenly St. Wheaton, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) OAT CELL CARCINOMA OF LUNG 1629 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): PERFORATED PEPTIC ULCER					
19a. DATE OF OPERATION 8-26-81		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED PERFORATED PEPTIC ULCER		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
21b. TIME OF INJURY 19 HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			
21f. LOCATION STREET		CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from Aug 15 , 19 81 , to Aug 30 , 19 81 , that (I) (we) last saw the deceased alive on Aug 30 , 19 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Paul A. Edwards		DEGREE M.B. BS		22c. DATE SIGNED 8/30/81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) PAUL ANDREW EDWARDS		22e. ADDRESS 8820 LANIER DRIVE #204 SILVERSPRING, M.D. 20910			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9/2/1981		23c. NAME OF CEMETERY OR CREMATORY Green Hill Cemetery	
23d. LOCATION CITY OR TOWN Waynesboro		COUNTY Franklin		STATE Penna.	
24. FUNERAL DIRECTOR NAME Grove Funeral Home		ADDRESS 50 S. Broad St. Waynesboro Pa.		25. DATE REC'D. BY REGISTRAR SEP 4 1981	
25. REGISTRAR'S SIGNATURE					

BP



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS ANTICIPATED, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 2. RETAIN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

FOR STATE REGISTRAR										DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.																			
1. DECEASED NAME (TYPE OR PRINT)					FIRST MIDDLE LAST					2a. DATE KNOWN OF ESTI- DEATH MATED					MONTH DAY YEAR					2b. HOUR																			
KAREN					LEE					DELAUDER					08					29					1981					3:37									
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS)			IF UNDER 1 YR.		IF UNDER 24 HRS.			7c. DATE PRONOUNCED DEAD					MONTH DAY YEAR					2d. HOUR														
Female		Cauc.		MARCH 17 63			18			MONTHS		DAYS			HOURS			MIN.			08					29					1981					3:37			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)					7b. CITIZEN OF WHAT COUNTRY?					8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					9. BALTIMORE CITY OR COUNTY OF DEATH																								
WASHINGTON DC					U.S.A.										MONTGOMERY County, MD.																								
10. CITY OR TOWN OF DEATH					11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)					12b. KIND OF BUSINESS OR INDUSTRY																			
SILVER SPRING					HOLY CROSS HOSPITAL										UNEMPLOYED					None																			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										13a. STATE										13b. COUNTY					13c. CITY OR TOWN					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					13e. STREET ADDRESS				
MD										MONTGOMERY					BETHESDA										10504 WESTLAKE DRIVE														
14. FATHER'S NAME FIRST MIDDLE LAST										15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST																													
LEE Franklin DELAUDER										DOROTHY NORRIS																													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)										16b. SOCIAL SECURITY NO.										17. INFORMANT ADDRESS																			
No										578-90-1187										Dorothy N. DeLawder, SAME as #13																			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple Injuries</u> DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).															None																								
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																								
None																																							
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH					21b. TIME OF INJURY HOUR AM MONTH DAY YEAR 2:40 P.M. FEB 29 1981					21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Motorcycle, truck collision																													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK					21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Street					21f. LOCATION STREET CITY OR TOWN COUNTY STATE Columbia Pike Burtonsville Mont MD																													
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .																																							
ACTUAL SIGNATURE										TITLE (SPECIFY) M.D. Dep										MEDICAL EXAMINER 1919 Seminary Road Silver Spring, Maryland																			
EXAMINER'S NAME (TYPE OR PRINT)										John S. Rogers, M.D.										DATE SIGNED Aug 24 1981																			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)					23b. DATE					23c. NAME OF CEMETERY OR CREMATORY					23d. LOCATION CITY OR TOWN COUNTY STATE																								
Burial					1, 1981					Forest Oak Cemetery					Gaithersburg, Maryland																								
24. FUNERAL DIRECTOR NAME ADDRESS										25a. DATE REC'D. BY REGISTRAR										25b. REGISTRAR'S SIGNATURE																			
Robert A. Pumphrey Funeral Homes, P.A. Bethesda, Maryland										SEP 4 1981										Frances Jan Nathan																			



Handwritten notes and signatures are visible across the page, including a large signature in the center and smaller notes at the bottom. The text is mostly illegible due to the quality of the scan and the handwriting.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR 1- STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
WILDA H. DELBIANCO		8 19 81		710 PM	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YEAR	
Female	White	8 23 28	53	MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
North Carolina	USA		MARYLAND MD		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR		
BETHESDA	HOSPITAL	US Gov't	Printing Specialist		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)	13b. CITY OR TOWN	13c. INSIDE CITY LIMITS?	13d. STREET ADDRESS		
Md.	Glendale	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	6506 Facchina Lane		
14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		
Wade Hampton Hasty	Lora Johnson		16b. SOCIAL SECURITY NO.		
			17. INFORMANT		
			ADDRESS		
			None		
			577 42 2850		
			Francis DelBianco (Husband) Same as above		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 1629 IMMEDIATE CAUSE (a) <u>metastatic Carcinoma of Lung</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>5 months</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Carcinoma of uterus, Diabetes mellitus.</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (the hospital) attended the deceased from <u>Aug 19 81</u> to <u>Aug 19 81</u> , that (I) (we) lost saw the deceased alive on <u>8-19</u> 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death.					
22b. SIGNATURE <u>John F. Taubor</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8-19-81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>John F. Taubor</u>		22e. ADDRESS 8218 Wisconsin Ave Bethesda Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/22/81		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery	
				23d. LOCATION CITY OR TOWN COUNTY STATE S.S. Mont. Maryland	
24. FUNERAL DIRECTOR NAME Hines/Rinaldi F.H.11800 N.H.Ave, S.S.Md.		25a. DATE REC'D. BY REGISTRAR AUG 21 1981		25b. REGISTRAR'S SIGNATURE <u>Thomas J. Taubor</u>	

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W.L.A.H. DEKORATION

MADRID

TESTED BY THE ARMY



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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 2 1 6 1 7

FOR
1 - STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) HELEN J. DENUNZIO			2a. DATE OF DEATH MONTH DAY YEAR 8-12-81		2b. HOUR 8:40AM
3. SEX female	4. RACE white	5. DATE OF BIRTH MONTH DAY YEAR 7 26 10		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Rockville, Md.	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SHADY GROVE ADVENTIST HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER	12b. KIND OF BUSINESS OR INDUSTRY None	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE Maryland	13b. COUNTY Montgomery	13c. CITY OR TOWN Gaithersburg	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 12144 Suffolk Terrace	
14. FATHER'S NAME FIRST MIDDLE LAST Allen Merrill Young			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Edith Elizabeth Rapetti		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 578-12-7585		17. INFORMANT ADDRESS Michael DeNunzio (same as 13e)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 4360 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) & CVA DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day 4 weeks
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a Diabetes, CHF, Hypertension					
19a. DATE OF OPERATION 8-3-81		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED GASTROSTOMY		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. certify that (I) (this hospital) attended the deceased from 8/11 7/8 19 81 to 8/12 19 81 , that (I) (we) lost saw the deceased alive on 8/11 19 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE W. G. Graf		DEGREE		22c. DATE SIGNED 8/12/81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MARTIN GRAF		22e. ADDRESS 13-15 E. DEER PARK DRIVE GAITHERSBURG MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1981 August 15	23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring Montg. Maryland
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey ADDRESS 300 W. Montgomery Ave., Rockville, Maryland		25a. DATE REC'D. BY REGISTRAR AUG 21 1981		25b. REGISTRAR'S SIGNATURE Thomas J. Heston	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filed within 72 hours after death. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filed within 72 hours after death. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified or once.



0600 BP



TO HOSPITAL BY ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 10 days after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 1 2 1 6 1 8			
FOR STATE REGISTRAR Olive P. Dorman				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) OLIVE P. DORMAN				2a. DATE OF DEATH MONTH DAY YEAR 8-26-81		2b. HOUR 3⁵⁰ A M	
3 SEX Female		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR 12-23-85		6 AGE (IN YEARS LAST BIRTHDAY) 95 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Mass.		7b. CITIZEN OF WHAT COUNTRY? US		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10 CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fernwood Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Home	
13a. STATE District of Columbia		13b. CITY OR TOWN Wash., D.C.		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS 4201 Fordham Rd. N.W.	
14 FATHER'S NAME FIRST MIDDLE LAST James Peacock		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Minnie Hueg		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			
16b. SOCIAL SECURITY NO 579-60-2896-D		17 INFORMANT Dr. Parker S. Dorman		ADDRESS Rockville, Md. 11104 Ardwick Dr.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cancer of the kidney 1890 DUE TO, OR AS A CONSEQUENCE OF (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost DUE TO, OR AS A CONSEQUENCE OF (c)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 18 months	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 24 1981 P.M.		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) this hospital attended the deceased from June 24 1981 to Aug 24 1981 , that (I) we lost saw the deceased alive on Aug 24 1981 , and that in (my our) opinion death occurred on the date and hour and from the causes stated above. (I) we (did not) view the body after death.							
22b. SIGNATURE John D. Herman DEGREE MD				22c. DATE SIGNED 8/26/81		22d. PHYSICIAN'S NAME (TYPE OR PRINT) John D. Herman	
22e. ADDRESS 4425 Montgomery Ave, Bethesda, Md				22f. MEDICAL PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/28/81		23c. NAME OF CEMETERY OR CREMATORY Oak Hill Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Wash., D.C.	
24 FUNERAL DIRECTOR Joseph Gawler's Sons, Inc. ADDRESS 5130 Wisc. Ave. N.W. Wash., D.C.				25a. DATE REC'D BY REGISTRAR SEP 01 1981		25b. REGISTRAR'S SIGNATURE Frances San Kristina	

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cleared with medical examiner - Dr. Mayle

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

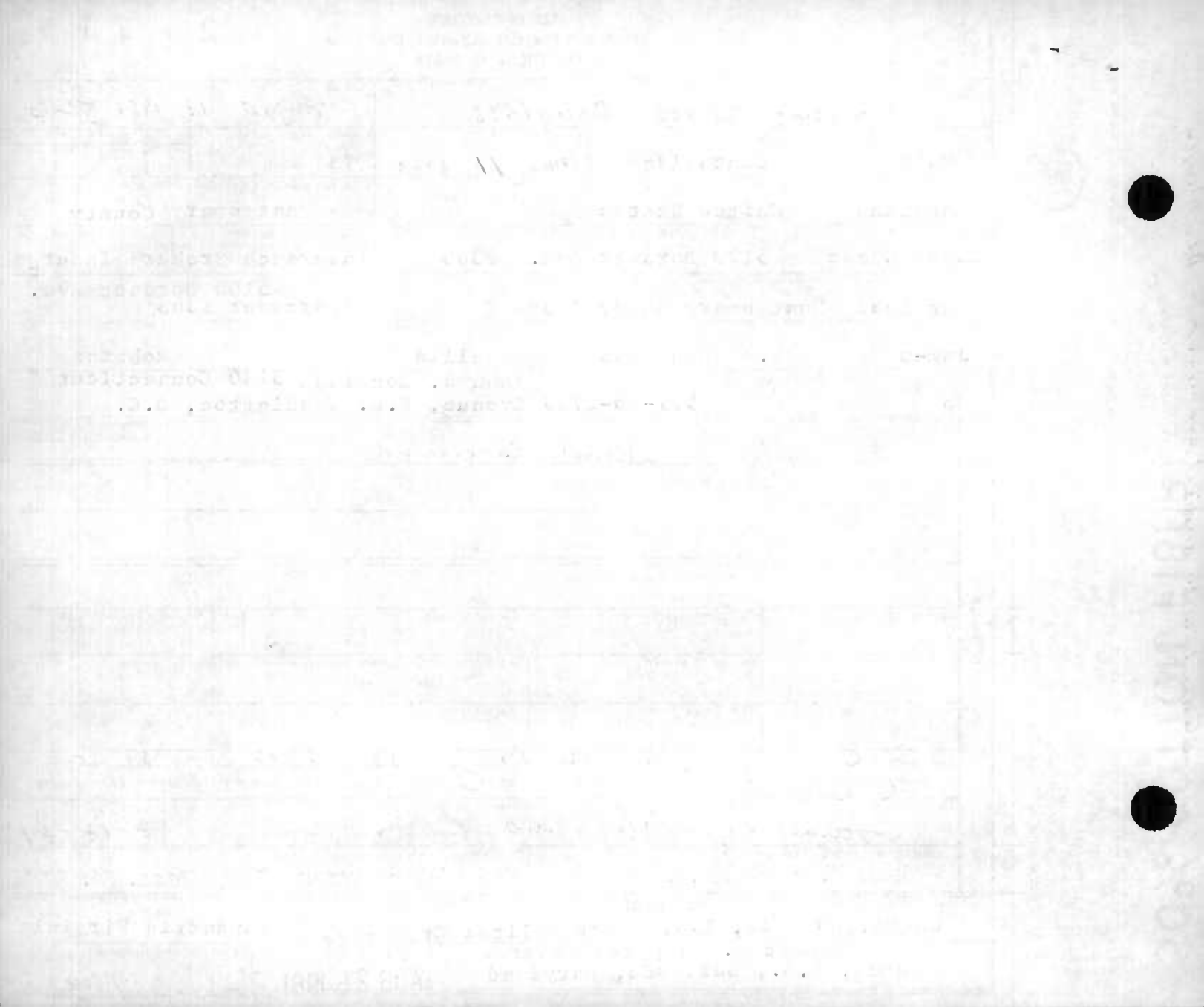
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the funeral director with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		7. REG. NO.		8. 1		2. 1		6. 1	
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH		MONTH		DAY	
James Edward Douglass				August 18 1981		5:10 P.M.			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR	
Male		Caucasian		May 18 1908		73		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Maryland		United States				Montgomery County MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Chevy Chase		5100 Dorsett Ave. #303				Insurance Broker		Insurance	
13a. USUAL RESIDENCE (IF NOT IN SUCH FACILITY, GIVE RESIDENCE BEFORE ADMISSION)				13b. INSIDE CITY LIMITS?		13c. STREET ADDRESS			
Maryland				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		5100 Dorsett Ave. Apartment #303			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME					
James E. Douglass				Nellie Robbins					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMATION			
No				577-10-2765		John S. Douglass 5180 Connecticut Avenue, N.W. Washington, D.C.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Renal carcinoma</u> 1890 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
		HOUR A.M. MONTH DAY YEAR							
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION					
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (this hospital) attended the deceased from <u>12-29</u> , 19 <u>78</u> , to <u>8-18</u> , 19 <u>81</u> , that (we) lost saw the deceased alive on <u>3-17</u> , 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE				DEGREE				22c. DATE SIGNED	
James H. Brodsky				M.D.				8-18-81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS					
James H. Brodsky, M.D.				4701 Willard Avenue Chevy Chase, Md. 20815					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION			
CREMATION		August 20, 1981		Metropolitan Crematory		Alexandria Virginia			
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Robert A. Pumphrey Funeral Homes, P.A., Bethesda, Maryland				AUG 28 1981		James H. Brodsky			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified in advance.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 1 2 1 6 2 0			
1. FOR STATE REGISTRAR				REG. NO.			
1 DECEASED NAME (TYPE OR PRINT) MARGARET DOUTHAT				2a. DATE OF DEATH MONTH DAY YEAR 8 29 81		2b. HOUR 7:35 a	
3 SEX F		4 RACE W		5 DATE OF BIRTH MONTH DAY YEAR 10 18 01		6 AGE (IN YEARS LAST BIRTHDAY) 79 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.	
10 CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Chevy Chase Nurs. Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Teacher		12b. KIND OF BUSINESS OR INDUSTRY Education	
13a. STATE Md.		13b. COUNTY Mont.		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO	
14 FATHER'S NAME FIRST MIDDLE LAST John T. Graves		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ida		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			
16b. SOCIAL SECURITY NO. 577-10-4562		17 INFORMANT ADDRESS Mr. James Douthat Silver Spring, Md.					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hepatic metastasis from 1749 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) carcinoma of right breast DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 months 4-5 months							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 8-26 to 8-29 19 81 , that (I) was lost above, (I) was did not view the body after death.							
22b. SIGNATURE Jason Geiger M.D. DEGREE				22c. DATE SIGNED 8-29-81		22d. PHYSICIAN'S NAME (TYPE OR PRINT) JASON GEIGER M.D.	
22e. ADDRESS 8830 CAMERON STREET SILVER SPRING, MD. 20910				23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal			
23b. DATE 8/29/81		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE		24 FUNERAL DIRECTOR NAME ADDRESS Anatomy Board Balto., Md.	
25a. DATE REC'D. BY REGISTRAR SEP 4 1981				25b. REGISTRAR'S SIGNATURE Thom D. ...			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 81-21621	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Ronald E. DOWNARD						2a. DATE OF DEATH MONTH DAY YEAR August 17 1981			2b. HOUR 3:47 M		
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Sept. 22 1939		6. AGE (IN YEARS LAST BIRTHDAY) 41 YRS.			IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Kentucky		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.					
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) National Naval Medical Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) U. S. Marine Corps			12b. KIND OF BUSINESS OR INDUSTRY Maj. (R)		
13a. STATE Virginia		13b. COUNTY Stafford		13c. CITY OR TOWN Stafford		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 2026 Victoria Drive			
14. FATHER'S NAME FIRST MIDDLE LAST Marshall Downard						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Evelyn Mae Harris					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES) 1961-81		17. INFORMANT Linda Downard		ADDRESS See item 13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Dissiminated lymphocytic lymphoma 2001 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I/ (this hospital) attended the deceased from Jul. 25 1981 to Aug. 17 1981 that I/ (we) last saw the deceased alive on Aug. 17 1981 , and that in my/ (our) opinion death occurred on the date and hour and from the causes stated above. (If we (did) view the body after death.											
22b. SIGNATURE <i>Joseph F. Hacker, III</i>						DEGREE M.D.		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED Aug. 18 1981	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Joseph F. HACKER, III, M.D.						22e. ADDRESS National Naval Medical Center, Bethesda, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE Aug. 20, 1981		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION CITY OR TOWN COUNTY STATE Arlington Arlington Va.			
24. FUNERAL DIRECTOR NAME <i>B. Em Mountcastle</i>						ADDRESS Cunningham Mountcastle Funeral Home Woodbridge		25a. DATE REC'D. BY REGISTRAR AUG 24 1981		25b. REGISTRAR'S SIGNATURE <i>Rene J. ...</i>	

MEDICAL CERTIFICATION

DHMH - 17
(VR A15 ME (5))
15M 7/76

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		MONTH		DAY		YEAR		2b. HOUR	
Wallace		J.		Duszynski				8/18		19		81				M	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR	
Male	White	Sep. 23 1919		61 YRS.						8/18		19		81		P. M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH								MD.	
New Jersey		USA		WIDOWED		DIVORCED		Montgomery County									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY											
Rockville		4826 Cherry Valley Drive		Violinist-Self Employed													
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS									
Maryland		Montgomery		Rockville		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		4826 Cherry Valley Drive									
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME															
John Duszynski		Sophia Skidicka															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS											
WWII		Yes		155 05 5556		Rosemary K. Duszynski (Wife)		Same as above									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		Carcinoma of lung with metastases.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
1629		DUE TO, OR AS A CONSEQUENCE OF		(b)		DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.		(c)															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).		Emphysema															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?													
None				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
		HOUR A.M. MONTH DAY YEAR		None													
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION													
				STREET		CITY OR TOWN		COUNTY		STATE							
22a. I certify that I took charge of the remains described above, held on		Autopsy <input type="checkbox"/>		Inspection <input checked="" type="checkbox"/>		Inquiry <input type="checkbox"/>		and in my opinion									
death resulted from:		Natural causes <input checked="" type="checkbox"/>		Accident <input type="checkbox"/>		Suicide <input type="checkbox"/>		Homicide <input type="checkbox"/>		Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE		TITLE (SPECIFY)		MEDICAL EXAMINER		DATE SIGNED		8/18/81									
EXAMINER'S NAME (TYPE OR PRINT)		John S. Rogers, M.D.		ADDRESS		1919 Seminary Road		Silver Spring, Montgomery, Md.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		CITY OR TOWN		COUNTY		STATE					
Burial		8/21/81		Gate of Heaven Cemetery		Silver Spring		Montgomery		Maryland							
24. FUNERAL DIRECTOR		NAME		ADDRESS													
Hines		Rinaldi F.H.11800		N.H.Ave.S.S.Md.													

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 21624	
1. DECEASED NAME (TYPE OR PRINT) Edward H. Duvall						2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR 8 26 19 81		2b. HOUR M 11:24 P			
3. SEX Male	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR May 22, 1920	6. AGE (IN YEARS LAST BIRTHDAY) 61 YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD 8 26 19 81		2d. HOUR P			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD.					
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) None		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Md.						13b. CITY OR TOWN Montg.		13c. STREET ADDRESS 8014 Spiceberry Lane			
14. FATHER'S NAME FIRST MIDDLE LAST Howard Duvall				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Edith Taylor							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO. 218-01-5503			17. INFORMANT ADDRESS Patricia Dotson (daughter) same as #13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple Injuries 8147 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR MIN. MONTH DAY YEAR 9:00 A.M. 8 26 19 81		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) pedestrian struck and run over by several autos						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) road		21f. LOCATION - STREET CITY OR TOWN COUNTY STATE Rt. 124 near Mineral Springs Dr., Gaithersburg, Montgomery Co., Md.						
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Virginia L. Dolan			TITLE (SPECIFY) M.D. Assistant			MEDICAL EXAMINER		DATE SIGNED 8-27-81			
EXAMINER'S NAME (TYPE OR PRINT) Virginia L. Dolan, M.D.			ADDRESS 111 Penn Street								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8-31-81		23c. NAME OF CEMETERY OR CREMATORY Emory Grove Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Gaithersburg, Montg. Md.				
24. FUNERAL DIRECTOR NAME George R. Snowden				ADDRESS 246 N. Washington Street Rockville, Md. 20850			25a. DATE REC'D. BY REGISTRAR SEP 2 1981		25b. REGISTRAR'S SIGNATURE		

Continued on next page
Date: 10/10/50
Page: 2 of 2

Handwritten notes and signatures, including "10/10/50" and "Page 2 of 2".

1. FOR STATE REGISTRAR

2. HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

3. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

4. IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 2 1 6 2 5

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) GRACE ALICE DYSON			2a. DATE OF DEATH MONTH 8 DAY 26 YEAR 81 5 ²⁷ PM		
3. SEX female	4. RACE white	5. DATE OF BIRTH MONTH 2 DAY 25 YEAR 1918	6. AGE (IN YEARS LAST BIRTHDAY) 63 YRS	IF UNDER 1 YEAR MONTHS 0 DAYS 0 HOURS 0 MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Tennessee	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD		
10. CITY OR TOWN OF DEATH Rockville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Shady Grove Adventist Hosp.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) housewife	12b. KIND OF BUSINESS OR INDUSTRY home	
13a. STATE Maryland			13b. COUNTY Montgomery	13c. CITY OR TOWN Rockville	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST Maurice MIDDLE Emmit LAST Taylor			15. MOTHER'S MAIDEN NAME FIRST Alice MIDDLE Ellis LAST Winters		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 413 66 4482	17. INFORMANT ADDRESS Rockville, Md. Lawrence Dixon 1016 Kennon Ct.		
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 4140 IMMEDIATE CAUSE (a) Cardiopulmonary Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c) Diabetes Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes year
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)					
Diabetes					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) (this hospital) attended the deceased from August 26, 1981 to August 26, 1981 , that (1) (we) saw the deceased alive on August 26, 1981 , and that (1) (we) (my) (our) opinion of death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Patricia Kellogg MD		DEGREE MD		22c. DATE SIGNED 8/26/81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) PATRICIA Kellogg / Stephen Jones		22e. ADDRESS 809 Viers M.H. Rd. Rockville, Md 20851			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/28/81	23c. NAME OF CEMETERY OR CREMATORY Cornett Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Mountain City Tenn.
24. FUNERAL DIRECTOR NAME Tyson Wheeler Funeral Home, Inc.			25. DATE RECEIVED BY REGISTRAR AUG 31 1981		
1331 Rockville Pike Rockville, Maryland					

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STATE ALICE J. JENKINS

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH VITAL RECORDS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 21626	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Carol Whiteford Earley			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 8/2 19 81			2b. HOUR A.M. <input type="checkbox"/> P.M. <input checked="" type="checkbox"/>					
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Oct. 22, 1895	6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD 8/3 19 81		2d. HOUR A.M. <input type="checkbox"/> P.M. <input checked="" type="checkbox"/>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Missouri		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD					
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3320 Gleneagles Drive, #2A			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Secretary		12b. KIND OF BUSINESS OR INDUSTRY US Gov't				
13a. STATE Maryland			13b. CITY OR TOWN Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
14. FATHER'S NAME FIRST MIDDLE LAST Not Available Whiteford			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Not Available								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) Not Available		17. INFORMANT Son 9 Abram Lane George W. Earley Bloomfield, Conn.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial disease.</u> 4291 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). None											
19a. DATE OF OPERATION None			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) None							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <i>John S. Rogers</i>		M.D. Deputy		MEDICAL EXAMINER		DATE SIGNED 8/3/81					
EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers, M.D.		ADDRESS 1919 Seminary Road Silver Spring, Montgomery, Md.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE Aug. 14, 1981		23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria, Virginia					
24. FUNERAL DIRECTOR NAME ROBERT A. PUMPHREY FUNERAL HOMES, P.A., BETHESDA, MARYLAND				25a. DATE REC'D. BY REGISTRAR AUG 18 1981		25b. REGISTRAR'S SIGNATURE <i>Thomas J. North</i>					



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										21627	
FOR 1- STATE REGISTRAR										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) John G. Eckert										2a. DATE KNOWN OF DEATH ESTIMATED Aug 31, 1981	
3. SEX M		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR June 30 1935		6. AGE (IN YEARS) LAST BIRTHDAY 45 YRS.		7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		2b. DATE PRONOUNCED DEAD Aug 31, 1981	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
10. CITY OR TOWN OF DEATH Sil. Spg.				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 11215 Oak Leaf Dr. Apt 208				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Property Management Corp.			
13a. STATE Md.				13b. COUNTY Montgomery		13c. CITY OR TOWN Sil. Spg.		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST John A Eckert				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Catherine Keeler				17. INFORMANT ADDRESS Adrienne Eckert (Wife) Same as above			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes				16b. SOCIAL SECURITY NO. 116 14 6310		17. INFORMANT ADDRESS Adrienne Eckert (Wife) Same as above				17. INFORMANT ADDRESS Adrienne Eckert (Wife) Same as above	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Dis DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION None				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? None				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE John P. Rogers						TITLE (SPECIFY) M.D. Dep.			MEDICAL EXAMINER DATE SIGNED Aug 31, 1981		
EXAMINER'S NAME (TYPE OR PRINT) John Rogers						ADDRESS 1919 Seminary Rd. S.S.Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 9/3/81		23c. NAME OF CEMETERY OR CREMATORY Arlington Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Arlington, Va.	
24. FUNERAL DIRECTOR NAME ADDRESS Hines/Rinaldi F.H. 11800 N.H. Ave. S.S.Md.						25. DATE REC'D. BY REGISTRAR SEP 2 1981					

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE JUDICIAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 1 AND 2 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 21628	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) <u>Michael Frank Elderkin</u>										2a. DATE KNOWN OF DEATH <u>Aug 30 1981</u>	
3. SEX <u>M</u>		4. RACE <u>W</u>		5. DATE OF BIRTH (MONTH DAY YEAR) <u>Oct 16 1940</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>40</u> YRS.		7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		2b. DATE PRONOUNCED DEAD <u>Aug 30 1981</u>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Maine</u>				7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>Montgomery MD.</u>	
10. CITY OR TOWN OF DEATH <u>Silver Spring</u>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>7902 Woodbury Dr.</u>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Auditor</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Govt.</u>	
13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <u>MD</u> 13b. COUNTY <u>Montg</u> 13c. CITY OR TOWN <u>Silver Spring</u>				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <u>204 Whitmoor</u>		13f. CITY OR TOWN <u>Montgomery</u>		13g. STATE <u>MD</u>	
14. FATHER'S NAME (FIRST MIDDLE LAST) <u>Franklin W. Elderkin</u>				15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST) <u>Virginia Small</u>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <u>Yes</u>				16b. SOCIAL SECURITY NO. <u>Viet Nam</u>		17. INFORMANT <u>Renee H. Elderkin-wife-(same as 13e)</u>		ADDRESS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gunshot wound to head</u> 9554 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>None</u>											
19a. DATE OF OPERATION <u>None</u>				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <u>Shot sale</u>				21b. TIME OF INJURY (HOUR MONTH DAY YEAR) <u>8:30 8/30/81</u>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <u>Home</u>		21f. LOCATION (CITY OR TOWN STREET) <u>Silver Spring</u>		COUNTY <u>Montg</u>		STATE <u>MD</u>	
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE <u>John S. Rogers</u>				TITLE (SPECIFY) <u>DME</u>				MEDICAL EXAMINER		DATE <u>Aug 30, 1981</u>	
EXAMINER'S NAME (TYPE OR PRINT) <u>John S. Rogers, DME</u>				ADDRESS <u>Silver Spring, Md.</u>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>				23b. DATE <u>9-3-1981</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Pittsfield</u>		23d. LOCATION (CITY OR TOWN COUNTY STATE) <u>Pittsfield Somerset ME</u>			
24. FUNERAL DIRECTOR'S NAME <u>Warner E. Pumphrey, Inc.</u>						ADDRESS <u>8434 Ga. Ave., S.S. Md.</u>		25a. DATE REC'D. BY REGISTRAR <u>SEP 3 1981</u>		25b. REGISTRAR'S SIGNATURE <u>James Van Natten</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Please remove carbon papers. Pages 1 and 2 should be filed in the office of the funeral director after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.


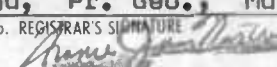
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
FOR 1. STATE REGISTRAR					REG. NO. 8 1 2 1 6 2 9					
1. DECEASED NAME (TYPE OR PRINT) Arthur ENDERLIN					2a. DATE OF DEATH MONTH DAY YEAR August 2 1981		2b. HOUR 1:15A M			
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Oct. 20 1902		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Michigan		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.				
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) National Naval Medical Center				12a. USUAL OCCUPATION (IF DECEASED WAS WORKING LIFE) Communicator Cpt U. S. Navy Ret		12b. KIND OF BUSINESS OR INDUSTRY Defense Dept.		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Montgomery		13c. CITY OR TOWN Bethesda		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 4411 Rosedale Avenue	
14. FATHER'S NAME FIRST MIDDLE LAST August Jack Enderlin					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Luise Kellar					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) Korea, WWII		17. INFORMANT Mrs. Eleanor Enderlin		ADDRESS See item 13				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory and cardiac failure 3369 DUE TO, OR AS A CONSEQUENCE OF (b) Myelodysplastic syndrome DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I (this hospital) attended the deceased from July 12 19 81 , to August 2 19 81 , that (I (we) last saw the deceased alive on August 2 19 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I (we) (did) (didn't) view the body after death.										
22b. SIGNATURE Stephen R. Veach						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED Aug. 4, 1981		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Stephen R. VEACH, M.C.						22e. ADDRESS National Naval Medical Center, Bethesda, Md.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE Aug 5, 1981		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory			23d. LOCATION CITY OR TOWN COUNTY STATE Suitland Pgs Md.		
24. FUNERAL DIRECTOR NAME W.W. Chambers Co.						ADDRESS Silver Spring, Md.		25a. RECEIVED BY REGISTRAR AUG 10 1981		

W. J. L. 100

At 21st John W. L. 100

At 21st John W. L. 100

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) Alcyone C. Facey			2a. DATE OF DEATH Month August Day 24 Year 1981			2b. HOUR 6:00 ^A M	
3. SEX Female		4. RACE Colored		5. DATE OF BIRTH July 18, 1905		6. AGE (In years last birthday) 76 YRS.	
7a. BIRTHPLACE (State or foreign country) Mississippi		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.	
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 14368 Good Hope Road		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Government Employee		12b. KIND OF BUSINESS OR INDUSTRY N.I.H.	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spr.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME Oliver H. Campbell		15. MOTHER'S MAIDEN NAME Sue Willie Wayne		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) No			
16b. SOCIAL SECURITY NO. 577-60-6805		17. INFORMANT Egbert G. Facey, 14368 Good Hope Rd, Silver Spr., Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4019 IMMEDIATE CAUSE (a) <u>Hypertension</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Years</u>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>7/15</u> , 19 <u>81</u> , to <u>8/12</u> , 19 <u>81</u> , that (I) (we) last saw the deceased alive on <u>8/12</u> , 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE 		DEGREE M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 8/27/81	
22d. PHYSICIAN'S NAME (Type) Michael E. Leibowitz, M.D.		22e. ADDRESS 11120 N.H. Ave., #505 Silver Spring, MD 20904					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Aug. 28, 1981		23c. NAME OF CEMETERY OR CREMATORY Lincoln Memorial Cem.		23d. LOCATION (City or Town) (County) (State) Suitland, Pr. Geo., Md	
24. FUNERAL DIRECTOR McGuire Funeral Ser., Inc.		ADDRESS 7400 Ga. Ave. NW Wash., D.C.		25a. REC'D BY REGISTRAR DATE AUG 27 1981		25b. REGISTRAR'S SIGNATURE 	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and on any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR		8 1 2 1 6 3 1 REG. NO.									
1 DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
MARGUERITE Dwyer FANNING								8/8/81		2:35 AM	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
FEMALE		White		09 10 96		84					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Texas		U.S.A.				Montgomery County MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
BETHESDA		SUBURBAN						Retired		Registered Nurse	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS	
		Maryland		Montgomery		Rockville				5704 Stillwell Road	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST									
UNKNOWN Dwyer		Annette Cunningham									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS					
Yes		WW I		226-22-5749		John C. Wileox		922 Jackson Street Annapolis, Md. 21403			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardioresp. Arrest</u> <u>4275</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>old age</u> (c) <u></u> DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>a</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN DETERMINING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I, OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) this hospital attended the deceased from <u>Aug 7</u> , 19 <u>81</u> , to <u>Aug 8</u> , 19 <u>81</u> , that (I have) last saw the deceased alive on <u>Aug 7</u> , 19 <u>81</u> , and that in (my own) opinion death occurred on the date and hour and from the causes stated above. (I have not) did not view the body after death.											
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED			
Carol Bender								8/8/81			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS									
Carol L. Bender		11125 Rockville Pike Rockville, Md. 20852									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
Cremation		8/11/81		Metropolitan		Alexandria Fairfax Virginia					
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
Lyson Wheeler Funeral Home, Inc.		AUG 12 1981		[Signature]							
1331 Rockville Pike Rockville, Maryland 20852											

1. The purpose of this study is to determine the effect of the new drug on the treatment of the disease.

2. The study was conducted in a double-blind, randomized, controlled trial.

3. The results of the study show that the new drug is significantly more effective than the placebo.

4. The study was limited by a small sample size and a short duration of follow-up.

5. Further studies are needed to confirm the results of this study.

6. The study was funded by the National Institutes of Health.

7. The study was conducted in accordance with the ethical principles of the Declaration of Helsinki.

8. The study was approved by the Institutional Review Board.

9. The study was published in the Journal of the American Medical Association.

10. The study was presented at the annual meeting of the American Society for Clinical Pharmacology.

11. The study was discussed in the media.

12. The study was cited in several textbooks.

13. The study was used as a basis for the development of new drugs.

14. The study was a landmark study in the field of pharmacology.

15. The study was a major contribution to the medical literature.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 1 2 1 6 3 2			
1. FOR STATE REGISTRAR				CERTIFICATE OF DEATH			
1. DECEASED NAME (TYPE OR PRINT)				7a. DATE OF DEATH			
Bridie Farley				MONTH DAY YEAR HOUR 8 29 81 5:10 PM			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	
Female		White		MONTH DAY YEAR Nov. 23, 1891		89 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Ireland		USA				Montgomery MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Beltsville		11402 Cherry Hill Rd. Apt. 302		Gimbles Dept. Store Sales			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13d. INSIDE CITY LIMITS?			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13e. STREET ADDRESS	
Md.		Mont.		Beltsville		11402 Cherry Hill Rd. Apt. 302	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME					
FIRST MIDDLE LAST		FIRST MIDDLE LAST					
Edward Conaty		Cathleen Brady					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
None		131 03 7062		Thomas E. Farley (Son) Same as above			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY:							
IMMEDIATE CAUSE (a) <i>Cardiac arrhythmia</i>							
3960 DUE TO, OR AS A CONSEQUENCE OF (b) <i>Disease of Heart - Aortic Stenosis and Mitral Insufficiency</i>							
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Known many yrs</i>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Arteriosclerotic Heart Disease</i>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
		P.M. 19					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the hospital) attended the deceased from <i>Nov 5</i> , 19 <i>81</i> , to <i>Aug 29</i> , 19 <i>81</i> , that (I) (we) lost saw the deceased alive on <i>Aug 26</i> , 19 <i>81</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE		DEGREE				22c. DATE SIGNED	
<i>Aaron H. Traum</i>		MD				<i>Aug 29 1981</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS					
Dr. Aaron H. Traum		8915 Ga. Ave. Silver Springs, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial		9/1/81		Gate of Heaven Cemetery		Hawthorne New York	
24. FUNERAL DIRECTOR				25. STATE REC'D. BY REGISTRAR (REGISTERED SIGNATURE)			
Hines/Rinaldi F.H. 11800 N.H. Ave. S.S. Md.				<i>[Signature]</i>			

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 2 1 6 3 3

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
NEAL BRADFORD		AUGUST 15, 1981		1:35 PM	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	7. BALTIMORE CITY OR COUNTY OF DEATH	
MALE	CAUCASIAN	OCT. 23, 1982	98	MONTGOMERY MD.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
USA MAINE	USA		MONTGOMERY MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
BETHESDA	NATIONAL NAVAL MEDICAL CENTER		U.S. NAVY		GOVT. (NAVY)
13a. STATE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. CITY OR TOWN	13c. INSIDE CITY LIMITS?	13d. STREET ADDRESS	
D.C.		WASHINGTON	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	3512 GARFIELD ST. N.W.	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16. ADDRESS	
HERBERT BRADFORD FARWELL		MARY E. BRANN		WASHINGTON, D.C.	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.	17. INFORMANT		
YES		1904-1945	CHARLES B. FARWELL, 3512 GARFIELD ST.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))					
PART I. DEATH WAS CAUSED BY: SEPSIS					
IMMEDIATE CAUSE (a)					
0389 DUE TO, OR AS A CONSEQUENCE OF					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
DUE TO, OR AS A CONSEQUENCE OF					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
		P.M. 19			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from AUGUST 13, 1981, to AUGUST 15, 1981, that (I/we) lost saw the deceased alive on AUGUST 15, 1981, and that in (my/our) opinion death occurred on the date and hour and from the causes stated above. (I/we) (did/did not) view the body after death.					
22b. SIGNATURE				22c. DATE SIGNED	
ROY S. SMALL, M.D.				AUGUST 15, 1981	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
ROY S. SMALL, M.D.		NAVAL HOSPITAL, BETHESDA, MD.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
BURIAL		8/20/81		ARLINGTON NATIONAL CEMETERY, ARLINGTON VA.	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
JOSEPH GAWLER SONS		AUG 21 1981		[Signature]	

MEDICAL CERTIFICATION

29

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 101

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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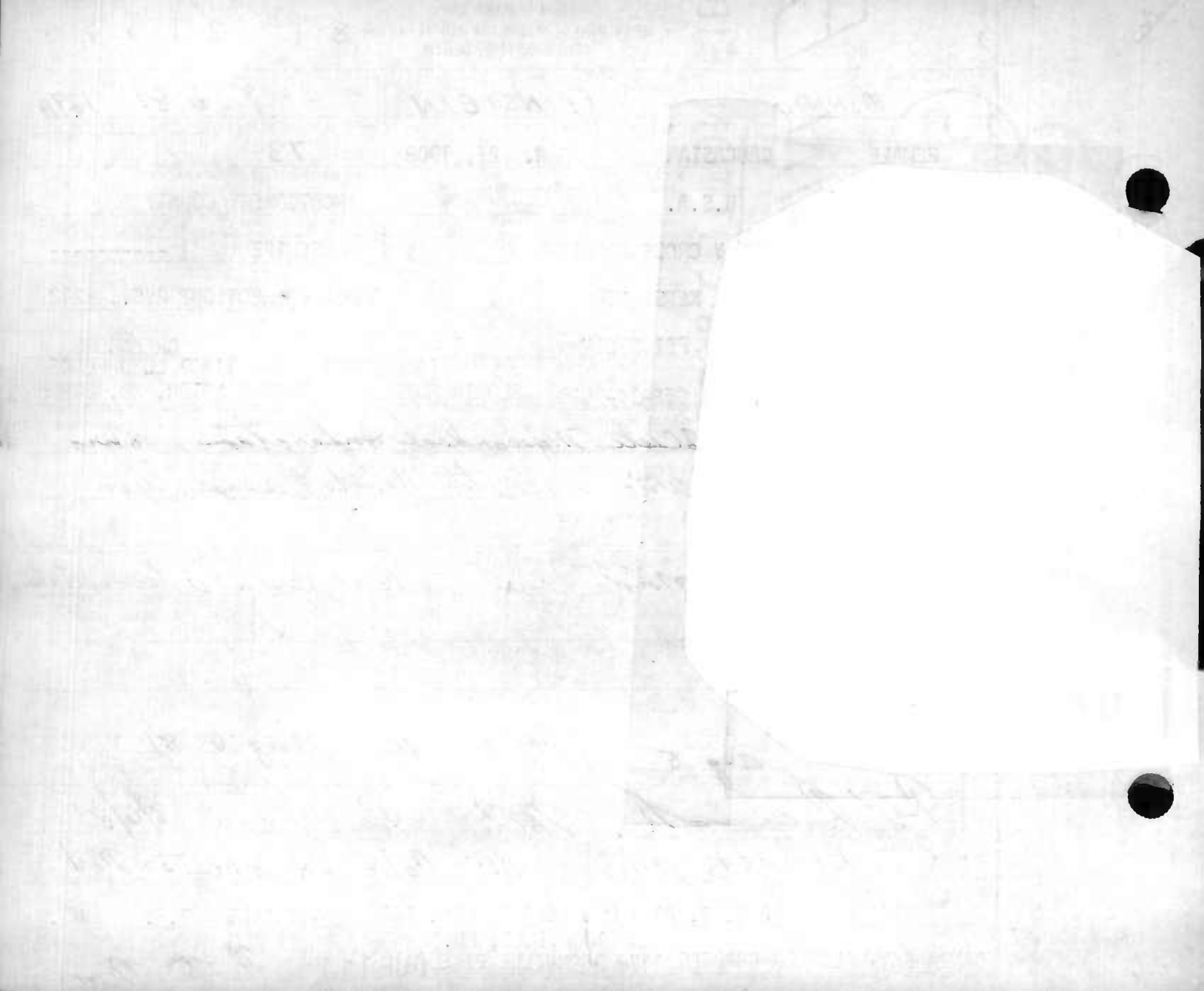
RECEIVED 15/05/68

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8	1	2	1	6	3	4
1- FOR STATE REGISTRAR										REG. NO.						
1. DECEASED NAME (TYPE OR PRINT) MINNIE FEINSTEIN										2a. DATE OF DEATH MONTH DAY YEAR 8 6 81				2b. HOUR 129A		
3 SEX FEMALE			4 RACE CAUCASIAN			5 DATE OF BIRTH MONTH DAY YEAR JAN. 25, 1908			6 AGE (IN YEARS (LAST BIRTHDAY)) 73 YRS				IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) RUSSIA			7b CITIZEN OF WHAT COUNTRY? U.S.A.			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD.							
10 CITY OR TOWN OF DEATH SILVER SPRING			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOLY CROSS HOSPITAL			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE				12b. KIND OF BUSINESS OR INDUSTRY -----						
13a STATE MARYLAND			13b COUNTY MONTGOMERY			13c CITY OR TOWN KENSINGTON			13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS 10920 CONNECTICUT AVE., #212					
14 FATHER'S NAME FIRST MIDDLE LAST SAUL FEINSTEIN						15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST IDA GREENBERG				16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO						
16b SOCIAL SECURITY NO. 068-14-7021						17 INFORMANT (DAUGHTER) GLORIA ROTTER				ADDRESS 11407 LUND PLACE KENSINGTON, MD. 20895						
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE Acute Myocardial Infarction 4100 DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 hrs yes						
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Emphysema, mild renal failure, cerebral arteriosclerosis																
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			19c AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)										
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET CITY OR TOWN COUNTY STATE										
22a I certify that (I) (this hospital) attended the deceased from June , 19 71 , to Aug 6 , 19 81 that (I) (we) lost saw the deceased alive on Aug 5 , 19 81 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did not) view the body after death.																
22b SIGNATURE R.T. Benack MD						DEGREE MD				22c DATE SIGNED 8/6/81						
22d PHYSICIAN'S NAME (TYPE OR PRINT) R.T. Benack MD						22e ADDRESS 4115 Polie Dr. Wheaton, Md.										
23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b DATE AUG. 7, 81			23c NAME OF CEMETERY OR CREMATORY MT. LEBANON MEM. PARK			23d LOCATION CITY OR TOWN COUNTY STATE HYATTSVILLE P.G. MD.							
24 FUNERAL DIRECTOR NAME DANZANSKY-GOLDBERG CHAPELS						ADDRESS 1170 ROCKVILLE PIKE				25a DATE REC'D. BY REGISTRAR 25b REGISTRAR'S SIGNATURE AUG 11 1981						



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified as soon as possible.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 1 2 1 6 3 5	
1. FOR STATE REGISTRAR			REG. NO.								
1. DECEASED NAME (TYPE OR PRINT) John Simmons Fentress			2a. DATE OF DEATH MONTH DAY YEAR 8 11 81			2b. HOUR M					
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 8 31 24		6. AGE (IN YEARS LAST BIRTHDAY) 56 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		7b. HOUR HRS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.C.		7b. CITIZEN OF WHAT COUNTRY? US		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.					
10. CITY OR TOWN OF DEATH Chevy Chase		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3519 Shepherd St.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Journalist			12b. KIND OF BUSINESS OR INDUSTRY News Magazine		
13a. STATE Md.			13b. COUNTY Montgomery		13c. CITY OR TOWN Chevy Chase		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 3519 Shepherd St.		
14. FATHER'S NAME FIRST MIDDLE LAST Clyde Deleon Fentress			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Minnie Simmons								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 243-22-6490			17. INFORMANT ADDRESS Ruth B. Fentress Same as item # 13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>shock</u> 1450 DUE TO, OR AS A CONSEQUENCE OF (b) <u>CANCER OF BUCAL MUCOSA</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>immed</u> <u>3 mo</u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (the doctor) attended the deceased from <u>June 1, 1981</u> to <u>Aug. 7, 1981</u> , that (I) (we) last saw the deceased alive on <u>Aug 7, 1981</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Aron Primack MD</u>			22c. PHYSICIAN'S NAME (TYPE OR PRINT) Aron Primack, M.D.			22d. ADDRESS 106 Irving St. N.W.			22e. DATE SIGNED 8/11/81		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 8/15/81		23c. NAME OF CEMETERY OR CREMATORY Greenleaf Mem. Pk.			23d. LOCATION CITY OR TOWN COUNTY STATE New Bern, N.C.			
24. FUNERAL DIRECTOR NAME Joseph Gawler's Sons, Inc. ADDRESS 5130 Wisc. Ave. N.W. Wash., D.C.						25a. DATE REC'D BY REGISTRAR AUG 17 1981			25b. REGISTRAR'S SIGNATURE <u>Thomas J. [Signature]</u>		

1410

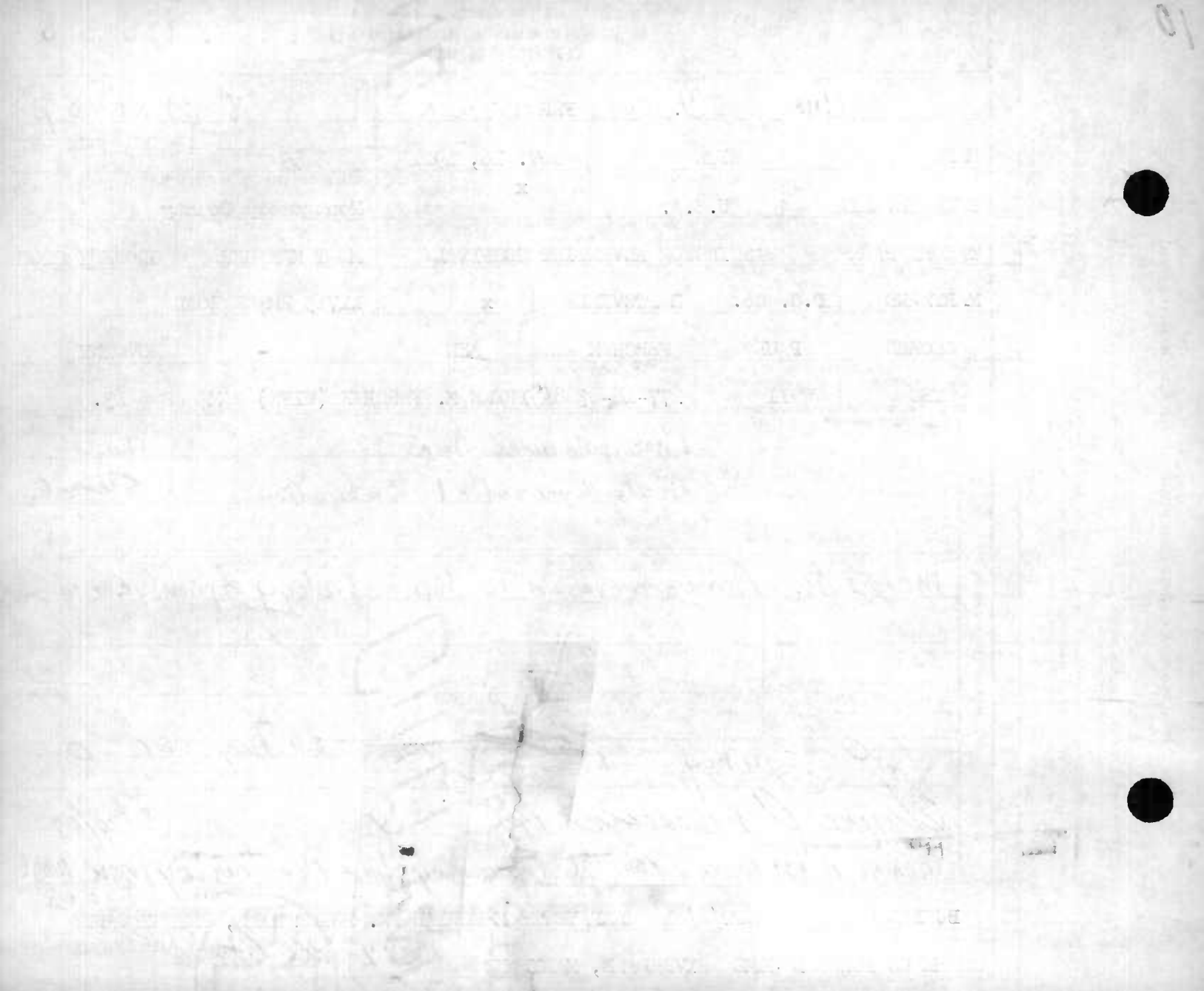
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1. FOR STATE REGISTRAR		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH	
FIRST MIDDLE LAST CARL P. FERCHAK		MONTH DAY YEAR HOUR 8 29 81 8:20 PM	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)
MALE	WHITE	MONTH DAY YEAR NOV. 16, 1921	59 YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH
PENNSYLVANIA	U.S.A.		Montgomery County MD.
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
TAKOMA PARK	WASHINGTON ADVENTIST HOSPITAL	MEAT MANAGER	GROCERY STORE
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?
MARYLAND	P.G. Co.	BELTSVILLE	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME	13e. STREET ADDRESS	
FIRST MIDDLE LAST GEORGE PAUL FERCHAK	FIRST MIDDLE LAST ANN - NOVOTNY	11715 EMACK ROAD	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)	17. INFORMANT ADDRESS	
YES	WWII	177-16-8388A IRENE M. FERCHAK (WIFE) SAME AS # 13.	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u> 4100 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Acute Myocardial Infarction</u> (c) <u>Sudden</u> DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hour
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Metastatic Adenocarcinoma To hip - etiology of primary site unknown</u>			
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY	20b. YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) this hospital attended the deceased from <u>20 July 1981</u> to <u>29 Aug 1981</u> , that (I) (we) last saw the deceased alive on <u>29 Aug 1981</u> , and that (my) (our) opinion death occurred on the date and hour and from the causes stated above (we) (did) (did not) see the body after death.			
22b. SIGNATURE		22c. DATE SIGNED	
<u>Thomas A. Bensinger MD</u>		<u>8/30/81</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS	
<u>THOMAS A. BENNINGER MD</u>		<u>7676 New Hampshire Ave, Langley Park MD</u>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE
BURIAL	SEPT/2/81	LAFAYETTE MEMORIAL PK.	BRIER HILL, PENNSYLVANIA 20783
24. FUNERAL DIRECTOR NAME		25. DATE REC'D. BY REGISTRAR REGISTRAR'S SIGNATURE	
CHAMBERS FUNERAL HOME RIVERDALE, MARYLAND		SEP 2 1981 <u>Theresa J. [Signature]</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the funeral director with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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BP

DHMH - 16 50M 1/81
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE						8 1 2 1 6 3 7	
1. FOR STATE REGISTRAR				CERTIFICATE OF DEATH			
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH			
Louise M. Fields				8/1/81			
3. SEX		4. RACE		5. DATE OF BIRTH		2b. HOUR	
Female		Black		2 08 31		1245P	
7a. BIRTHPLACE		7b. CITIZEN OF WHAT COUNTRY?		6. AGE (IN YEARS LAST BIRTHDAY)		8. IF UNDER 1 YEAR	
Washington, D.C.		USA		50		MONTHS DAYS HOURS MIN.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION		9. BALTIMORE CITY OR COUNTY OF DEATH		12a. USUAL OCCUPATION	
Silver Spring		Holy Cross		Montgomery County		Retired	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
Wheaton Md.		Mont		Wheaton		YES X NO	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		13e. STREET ADDRESS		17. INFORMANT	
James D. Anderson		Emma Wilcox		901 Arcola Ave.		Michael Anderson, Chillum, Maryland	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		ADDRESS		17. INFORMANT	
No		579-40-2344		5425 16th Ave.		Michael Anderson, Chillum, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
4310 CEREBRAL HEMMORHAGE				4 DAYS			
IMMEDIATE CAUSE (a)							
DUE TO, OR AS A CONSEQUENCE OF							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost							
DUE TO, OR AS A CONSEQUENCE OF							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES NO		YES NO	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED			
(IF EITHER, NOTIFY MEDICAL EXAMINER)		HOUR A.M. MONTH DAY YEAR		ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2			
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION			
WHILE AT WORK NOT WHILE AT WORK		[AT HOME STREET FACTORY, OFFICE, FARM, ETC.]		STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) <u>did</u> attend the deceased from <u>1 AUG 1981</u> to <u>1 AUG 1981</u> , that (I) <u>lost</u> saw the deceased alive on <u>1 AUG 1981</u> and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>did</u> view the body after death.							
22b. SIGNATURE				22c. DATE SIGNED			
WALTER E. GOOZH MD				1 AUG 81			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			
WALTER E. GOOZH MD				2309 SHOREFIELD RD WHEATON MD			
23a. BURIAL, CREMATION, REMOVAL		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION	
Burial		8/8/81		Harmony Memorial		Landover, Md.	
24. FUNERAL DIRECTOR				25a. DATE REC'D BY REGISTRAR		25b. SIGNATURE	
Sam Butler Inc Funeral Home				AUG 11 1981		James J. Martin	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8	1	2	1	6	3	8
1. FOR STATE REGISTRAR										REG. NO.						
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST LEO H FISK										2a. DATE OF DEATH MONTH DAY YEAR August 12, 1981				2b. HOUR 5 09 P^M		
3. SEX Male			4. RACE White			5. DATE OF BIRTH MONTH DAY YEAR May 22, 1919			6. AGE (IN YEARS LAST BIRTHDAY) 62 YRS.			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Hungary			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.							
10. CITY OR TOWN OF DEATH Silver Spring			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Program Specialist				12b. KIND OF BUSINESS OR INDUSTRY Dept. Labor						
13a. STATE Maryland			13b. COUNTY Montgomery			13c. CITY OR TOWN Bethesda			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 5101 River Road					
14. FATHER'S NAME FIRST MIDDLE LAST Manuel -- Fisch						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Betty -- (Unknown)										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes WW II						16b. SOCIAL SECURITY NO. 119-01-5856		17. INFORMANT ADDRESS Dorothy Fisk, Same address as # 13.								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Cerebro Vascular accident 4360 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 mos. 6 yrs.						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a																
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN IDENTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME STREET, FACTORY OFFICE FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from Apr. 6, 1981 to 8/12, 1981 that 6 (we) last saw the deceased alive on 8/12, 1981 and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																
22b. SIGNATURE Myron L. Lenkin								DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED August 12, 1981						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MYRON L. LENKIN MD								22e. ADDRESS 2309 Shorefield Rd. Wheaton, Md. 20209								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 8/15/81		23c. NAME OF CEMETERY OR CREMATORY Lawn Side Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Woodstown, New Jersey						
24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc. NAME ADDRESS 5130 Wisconsin Ave., NW, Washington, D.C. 20016								25a. DATE REC'D. BY REGISTRAR AUG 18 1981 25b. REGISTRAR'S SIGNATURE Thomas J. [Signature]								



Inc.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 2 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE KNOWN OF DEATH			2b. HOUR		
Michael Joel Flax			8 8 19 81			7a. HOUR		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	IF UNDER 1 YR.	IF UNDER 24 HRS.	7c. DATE PRONOUNCED DEAD	7d. HOUR	
Male	White	Apr. 11, 1930	51			8 8 19 81	7A. 57	
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		
N. Y.		USA				Montgomery County		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
Silver Spring		13119 Foxhall Drive				Economist		U. S. Govt.
13a. STATE			13b. CITY OR TOWN	13c. INSIDE CITY LIMITS?	13d. STREET ADDRESS			
Md			Montgomery	Silver Spring	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13119 Foxhall Drive		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME					
Benjamin Flax			Rebecca Sleppin					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?			16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
No			117-24-6438		Silver Spring			
					Mrs. Elayne Flax-13119 Foxhall Dr.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I DEATH WAS CAUSED BY:								
IMMEDIATE CAUSE (a) <u>Exsanguination</u>								
DUE TO, OR AS A CONSEQUENCE OF								
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.								
(b) <u>Multiple incised wounds</u>								
DUE TO, OR AS A CONSEQUENCE OF								
(c)								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?	
							YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
			? P.M. 8 8 19 81		self inflicted			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION			
			home		13119 Foxhall Drive, Silver Spring, / Maryland			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE			TITLE (SPECIFY)			DATE SIGNED		
Thomas D. Smith			Deputy Chief			8/9/81		
EXAMINER'S NAME			ADDRESS					
Thomas D. Smith, M.D.			111 Penn Street, Baltimore, MD. 21201					
23a. BURIAL, CREMATION, REMOVAL		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		
Burial		8/10/81		Judean Memorial Gardens, Olney		Montgomery, Md.		
24. FUNERAL DIRECTOR				25a. DATE RECD. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
NAME				ADDRESS				
Danzansky-Goldberg, Inc.				1170 Rockville Pike				

5



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

1. FOR STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 1 2 1 6 4 0 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) CLARA FLEMING				2a. DATE OF DEATH MONTH DAY YEAR 8 10 81				2b. HOUR 6:20 AM			
3 SEX F		4 RACE Cauc.		5 DATE OF BIRTH MONTH DAY YEAR 8 29 95		6 AGE (IN YEARS LAST BIRTHDAY) 85 YRS		7a. UNDER 1 YEAR MONTHS DAYS 8 10 81		7b. UNDER 24 HRS HOURS MIN 6:20 AM	
7c. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENNSYLVANIA				7d. CITIZEN OF WHAT COUNTRY? U.S.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
9a. Silver Spring, Maryland				9b. Retired				9. BALTIMORE CITY OR COUNTY OF DEATH Thurgate MD			
10. CITY OR TOWN OF DEATH Silver Spring				11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Retired				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE			
12b. KIND OF BUSINESS OR INDUSTRY HOME				13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE MD				13c. CITY OR TOWN Laurel			
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS 209 C Crescent Apts				14. FATHER'S NAME FIRST MIDDLE LAST FERDINAND Mc EUGENE MILLER			
15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ANNA LAURA PARKS				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 217-05-1333			
17. INFORMANT HAROLD FLEMING				17a. ADDRESS 1205 WHITE WAY				17b. CITY OR TOWN LAUREL, MD			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) congestive Heart Failure 4960 DUE TO, OR AS A CONSEQUENCE OF (b) arteriosclerotic Cardiovascular Disease DUE TO, OR AS A CONSEQUENCE OF (c) chronic obstructive lung disease										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 1 22 19 81				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE 1420 Laurel Park Dr Laurel MD			
22. I certify that (I) (this hospital) attended the deceased from 8-9 19 81 , to 8-9 19 81 , that (I) (we) last saw the deceased alive on 8-9 19 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (did) (did not) view the body after death.											
22a. SIGNATURE Manjula				DEGREE				22b. DATE SIGNED 8-10-81		22c. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) B. G. MANJUNALA, MD				22e. ADDRESS 1420 Laurel Park Dr Laurel MD							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL				23b. DATE AUG. 13, 1981		23c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN CEM				23d. LOCATION CITY OR TOWN COUNTY STATE BRENTWOOD MD	
24. FUNERAL DIRECTOR NAME DONALDSON FUNERAL HOME				ADDRESS LAUREL MD				25a. DATE REC'D. BY REGISTRAR AUG 20 1981		25b. REGISTRAR'S SIGNATURE Manjula	

1. The first part of the report is a general statement of the purpose and scope of the study. It is followed by a brief review of the literature on the subject.

2. The second part of the report is a description of the methods used in the study. This includes a discussion of the subjects, the instruments used, and the procedures followed.

3. The third part of the report is a presentation of the results of the study. This is followed by a discussion of the results and their implications.

4. The fourth part of the report is a conclusion. This is followed by a list of references and an appendix.

5. The fifth part of the report is a list of references. This is followed by an appendix.

6. The sixth part of the report is an appendix. This is followed by a list of references and an appendix.

3
Cleared by Dr. John Rogers
DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 1 2 1 6 4 1							
1- FOR STATE REGISTRAR				CERTIFICATE OF DEATH							
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH				2b. HOUR			
IDA FOSTER				Aug 31 1981				8:56 P M			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
female		white		March 5, 1894		87 YRS.		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
New York		USA				Montgomery MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION						12a. USUAL OCCUPATION		12b. KIND OF BUSINESS OR INDUSTRY	
Silver Spring		Holy Cross Hosp., Silver Spg., Md.						Secretary		Aircraft	
13a. STATE				13b. COUNTY		13c. CITY OR TOWN		13d. STREET ADDRESS			
Maryland				Monty		Silver Bpg		810 Brantford Ave			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME							
Arthur unk unk				Louis unk Lohouse							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO		17. INFORMANT		ADDRESS			
none				no		Mrs. Ginger King		810 Brantford Ave. S.S.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4140 Cardiac arrest				12 hours							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last				(b) Coronary artery hypertension				years			
				(c) Heart disease							
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)				Probable adenocarcinoma of fundus of uterus							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED		(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
		HOUR A.M. MONTH DAY YEAR									
		P.M. 19									
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION							
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME		(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		STREET		CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (the hospital) attended the deceased from July 25, 1981 to Aug 31, 1981, that (I) (we) lost the deceased alive on above, (I) (we) did not observe the body after death.				22b. SIGNATURE				DEGREE		22c. DATE SIGNED	
				JASON GEIGER, MD.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL STAFF <input type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		8-21-81			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS							
JASON GEIGER, MD.				8830 CAMERON STREET SILVER SPRING, MD. 20910							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION					
Cremation		Sept. 1, 1981		Cedar Hill Crematory		Suitland P.G. Md.					
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR					
W. W. Chambers, Co Inc				SEP 4 1981		M. J. [Signature]					
8655 Georgia Ave, Sil. Spg., Md. 20910											



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY OCCURS, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE MEDICAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGES 1 AND 2 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 21642	
1. DECEASED NAME (TYPE OR PRINT) Thelma Laurine Foster						2a. DATE KNOWN OF DEATH <input type="checkbox"/> MONTH <input checked="" type="checkbox"/> DAY <input type="checkbox"/> YEAR 8-3 1981		2b. HOUR P			
3. SEX Female	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR May 30, 1901	6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS.	7c. DATE PRONOUNCED DEAD August 3 1981	2d. HOUR 7:45				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Kansas		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD.					
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4949 Battery Lane, #401				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Home			
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Bethesda		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 4949 Battery Lane #401			
14. FATHER'S NAME FIRST MIDDLE LAST Elmer Allen Shaver				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Grace Olive							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 217-46-9156		17. INFORMANT ADDRESS St. Leonard, Maryland 20685 Jeanne Young P.O. Box 518A							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular Disease 4960 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) Chronic Obstructive Pulmonary Disease DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE John G. Ball			TITLE (SPECIFY) Deputy			DATE SIGNED August 4, 1981					
EXAMINER'S NAME (TYPE OR PRINT) John G. Ball			ADDRESS 7936 Old Georgetown Road Bethesda, Maryland 20814								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 1981 August 6,		23c. NAME OF CEMETERY OR CREMATORY Cemetery Arlington National		23d. LOCATION CITY OR TOWN COUNTY STATE Arlington, Virginia				
24. FUNERAL DIRECTOR NAME Robert A. Humphrey Funeral Homes, P.A. Bethesda, Maryland					25a. DATE REC'D. BY REGISTRAR AUG 7 1981		25b. REGISTRAR'S SIGNATURE James J. [Signature]				

RECEIVED

OFFICE OF THE ATTORNEY GENERAL

STATE OF NEW YORK

IN SENATE

JANUARY 1, 1911

REPORT

OF THE

COMMISSIONER OF

THE LAND OFFICE

FOR THE YEAR

ENDING

DECEMBER 31, 1910

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PRINTED BY

THE STATE PRINTING OFFICE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.FOR
1- STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) MARIE ADELAIDE FOWLER			2a. DATE OF DEATH MONTH DAY YEAR 8-21-1981			2b. HOUR 7:25 AM			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR June 15 1885		6. AGE (IN YEARS LAST BIRTHDAY) 96 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Michigan		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.			
10. CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) WASHINGTON ADVENTIST HOSP.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STREET CITY STATE Manor Care Prince Geo Adelphi				13c. CITY OR TOWN Adelphi		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1801 Metzzerott Rd.	
14. FATHER'S NAME FIRST MIDDLE LAST Michael J. X Schimmel				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Augustus Henning					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 220-44-4024		17. INFORMANT ADDRESS Charles R. Fowler 503 E. Melborne Ave Silver Spring, MD					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Terminal cerebral Infarction 2500 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) Diabetic Mellitus DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Aug 1981 years									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 1978 , 19____, to 8/21/81 , 19____, that (I) (we) lost saw the deceased alive on 8/21/81 , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE 			DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 8/21/81			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) OSOOTH LEKAGUL MD			22e. ADDRESS 7425 Arlington Rd Bethesda Md						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Aug. 26, 1981		23c. NAME OF CEMETERY OR CREMATORY Greenwood Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE City Michigan LaPorte, Ind.		
24. FUNERAL DIRECTOR NAME Warner E. Pumphrey, Inc			8434 Georgia Ave Sil. Spr. MD			25a. DATE REC'D. BY REGISTRAR AUG 25 1981		25b. REGISTRAR'S SIGNATURE 	

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
REG. NO. 81 21644											
1. DECEASED NAME (TYPE OR PRINT) Leona G. Fuls						2a. DATE OF DEATH MONTH 8 DAY 2 YEAR 81		2b. HOUR 11¹⁵ P.M.			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH May DAY 27 YEAR 1900		6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS		IF UNDER 1 YEAR MONTHS DAYS 		IF UNDER 24 HRS HOURS MIN 	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.					
10. CITY OR TOWN OF DEATH Gaithersburg		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Wilson Health Care Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret'd Vice-Pres.		12b. KIND OF BUSINESS OR INDUSTRY 1st Nat. Bank			
13a. STATE Md.						13b. COUNTY Montgomery		13c. CITY OR TOWN Gaithersburg		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST Edgar MIDDLE - LAST Fulks				15. MOTHER'S MAIDEN NAME FIRST Gertrude MIDDLE Elizabeth LAST Walker				13e. STREET ADDRESS 29 Walker Avenue			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) -		17. INFORMANT Estelle F. Hildebrand		ADDRESS Towson, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lymphoma, upper 2028 DUE TO, OR AS A CONSEQUENCE OF lymphoma, upper Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) primarily - progressed to stage 10 DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Months											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 											
19a. DATE OF OPERATION 3-16-81		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Lymphoma				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 19 50 to 8-2 19 81 , that (I) (we) last saw the deceased alive on 8-2-81 19 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Jack Schumacher M.D. DEGREE M.D.						ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jack Schumacher, M.D.						22e. ADDRESS 105 Russell Ave., Gaithersburg, Md. 20877					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/6/81		23c. NAME OF CEMETERY OR CREMATORY Forest OAK Cemetery		23d. LOCATION CITY OR TOWN Gaithersburg COUNTY Montgomery STATE Md.		23e. LOCATION STATE Md.			
24. FUNERAL DIRECTOR NAME Gartner Sandison F.H.		316 E. Diamond Ave.,		25. RECEIVED BY REGISTRAR REC-1		26. REGISTRAR'S SIGNATURE 					
		Gaithersburg, Md. 20877									

04

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Milton R Fusselman						2a. DATE OF DEATH MONTH DAY YEAR 8-25-81				2b. HOUR 1:19 M	
3. SEX MALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR 7-17-32		6. AGE (IN YEARS LAST BIRTHDAY) 49 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENNSYLVANIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD					
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ARCH SUP. EVIR.			12b. KIND OF BUSINESS OR INDUSTRY SYSTEMS INC.		
13a. STATE VIRGINIA		13b. COUNTY ARLINGTON		13c. CITY OR TOWN ARLINGTON		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 9559 BLAKE LANE			
14. FATHER'S NAME FIRST MIDDLE LAST JESSE MILTON FUSSELMAN				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST GERALDINE BOYNTON							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. 201-18-3106		17. INFORMANT WIFE ADDRESS JENNINGS, MISSOURI ROSE M. FUSSELMAN, 48 JENDALE CT.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gastrointestinal hemorrhage</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Metastatic Carcinoma</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>8/20</u> 19 <u>81</u> , to <u>8/25</u> 19 <u>81</u> , that (I) (we) last saw the deceased alive on <u>8/25</u> 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.											
22b. SIGNATURE <u>Jay Weiner MD</u>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 8/25/81			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jay Weiner				22e. ADDRESS 50 W Edmonston Dr Rockville, Md 20851							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE 8/28/81		23c. NAME OF CEMETERY OR CREMATORY METROPOLITAN CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE ALEXANDRIA VIRGINIA					
24. FUNERAL DIRECTOR'S NAME FRANCIS J. COLLINS						25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE SEP 2 1981 <u>Francis J. Collins</u>					
500 UNIV. BLVD., W., SILVER SPRING, MD. 20901											

U. S. DEPARTMENT OF AGRICULTURE
BUREAU OF PLANT INDUSTRY

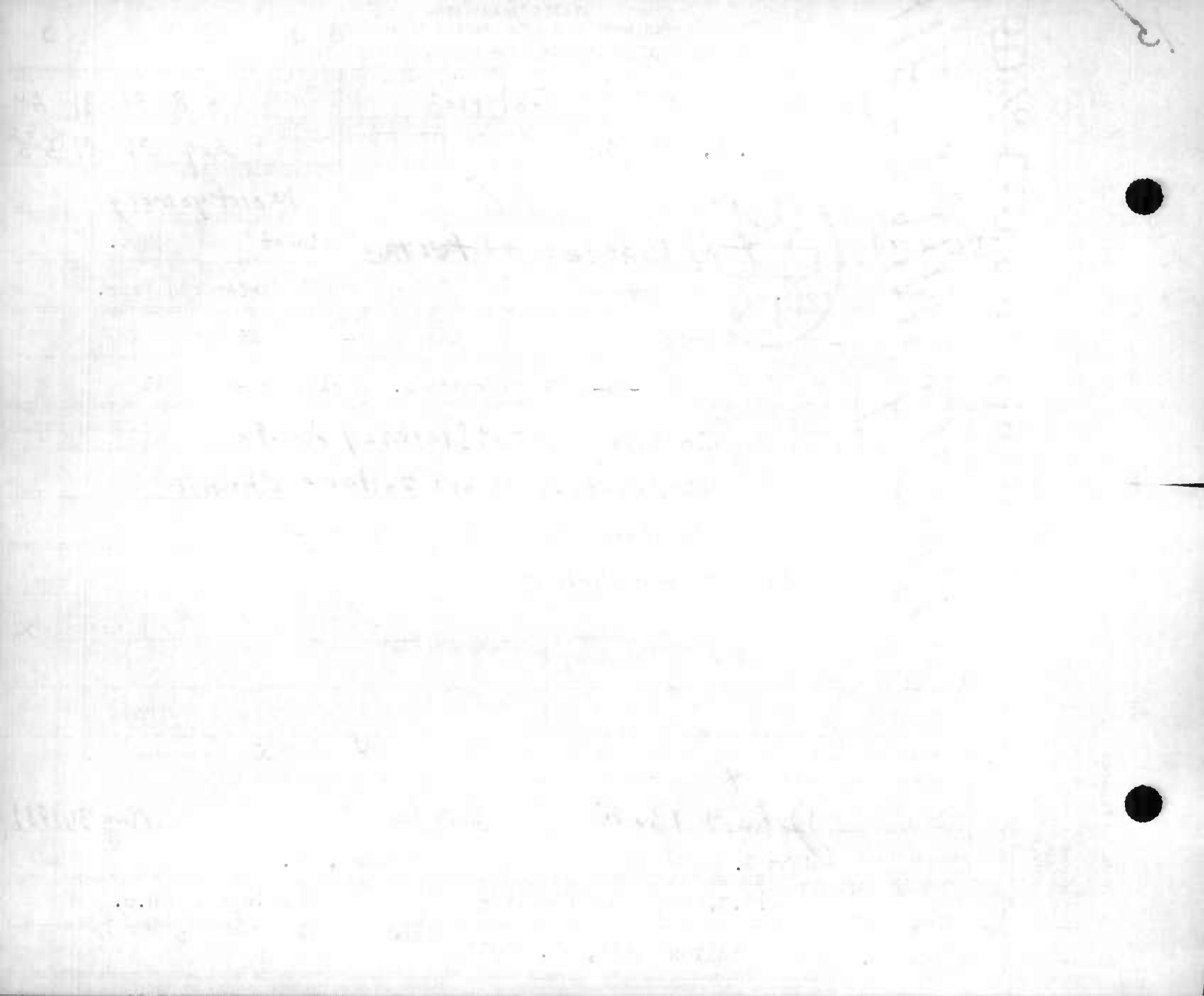
Report on the results of the
investigation of the
plant industry of the
United States, made by
the Bureau of Plant Industry,
Department of Agriculture,
in the year 1890.

By J. H. COOPER, Chief of Bureau.

Published by the Government Printing Office,
Washington, D. C., 1891.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 21646			
1. FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT) David. DAVID S. SAMUEL Gabriel							2a. DATE KNOWN OF DEATH 8-31-81		2b. HOUR AM	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH OCT. 1, 1919		6. AGE (IN YEARS) 61		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD Aug 31 1981		7d. HOUR 5:30 PM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ohio			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery				
10. CITY OR TOWN OF DEATH Derwood			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 7701 Baederwood Terr.			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Engineer			12b. KIND OF BUSINESS OR INDUSTRY Gov.				
13a. STATE Maryland			13b. COUNTY Mont.		13c. CITY OR TOWN Derwood		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 7701 Baederwood Terr.				
14. FATHER'S NAME John - Gabriel						15. MOTHER'S MAIDEN NAME Lucy - Kirby							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no			16b. SOCIAL SECURITY NO. 299-03-1473			17. INFORMANT ADDRESS DeEtte A. Gabriel Same as #13							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 4255 IMMEDIATE CAUSE (a) Coronary Insufficiency Acute DUE TO, OR AS A CONSEQUENCE OF (b) congestive Heart Failure Chronic DUE TO, OR AS A CONSEQUENCE OF (c) alcoholic Cardiomyopathy PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): Chronic Alcoholism												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?									20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE John G. Ball			TITLE (SPECIFY) Deputy			MEDICAL EXAMINER			DATE SIGNED Aug 31, 1981				
EXAMINER'S NAME (TYPE OR PRINT) John G. Ball MD			ADDRESS Bethesda, Md.										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION			23b. DATE SEPT. 3, 1981			23c. NAME OF CEMETERY OR CREMATORY Lee Crematory			23d. LOCATION CITY OR TOWN Washington D.C. STATE				
24. FUNERAL DIRECTOR NAME FRANCIS H. BARBER			ADDRESS LAYTONSVILLE, MD. 20879			25a. FILED BY SEP 1 1981			25b. REGISTRAR'S SIGNATURE James J. [Signature]				

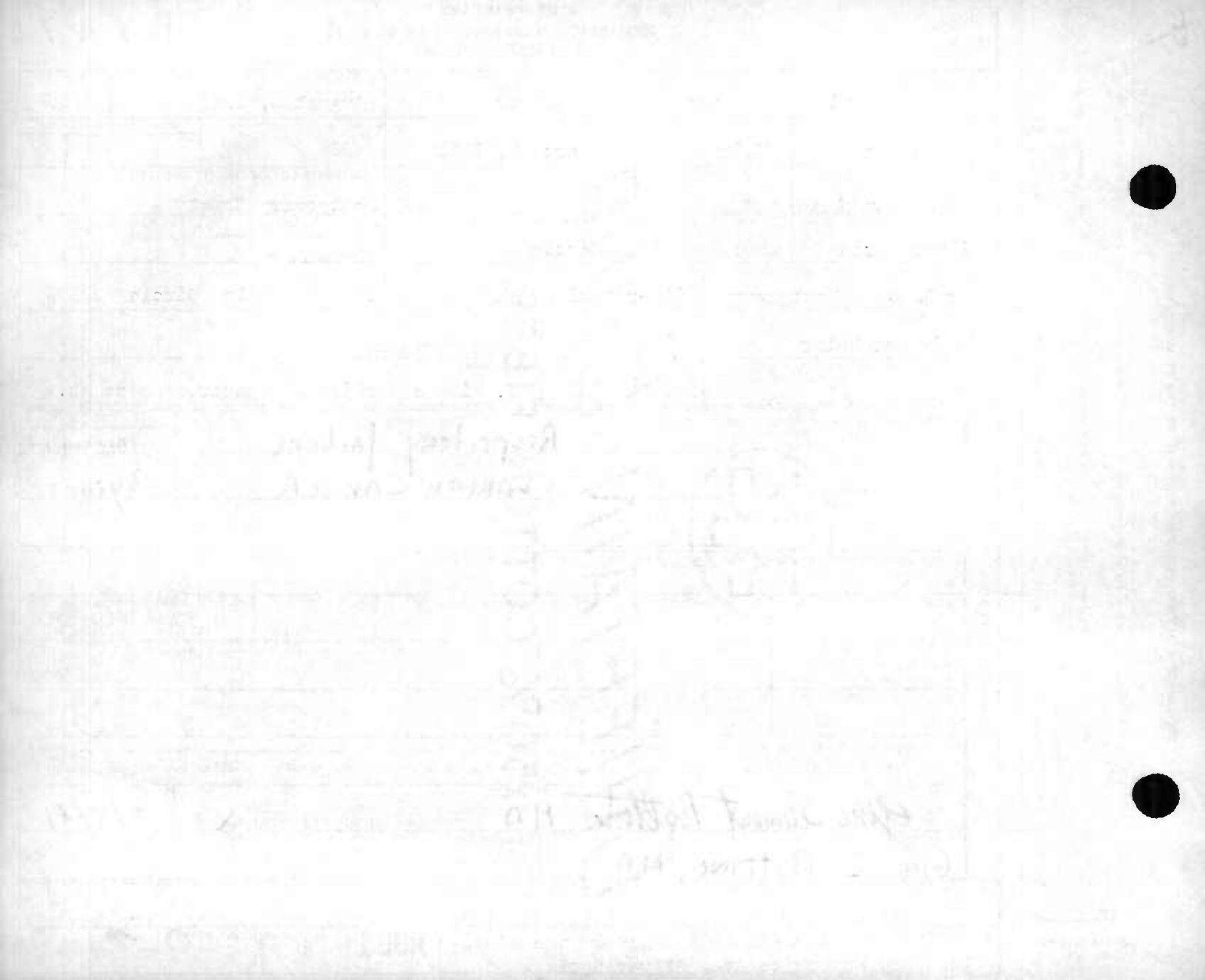


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 1 2 1 6 4 7	
1. FOR STATE REGISTRAR				CERTIFICATE OF DEATH	
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH	
Avis Lee Gardner				August 3, 1981	
3. SEX Female		4. RACE White		5. DATE OF BIRTH March 3, 1923	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina		7b. CITIZEN OF WHAT COUNTRY? USA		6. AGE (IN YEARS LAST BIRTHDAY) 58	
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2386 Sunvalley Circle		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring	
14. FATHER'S NAME Brady Batchelor		15. MOTHER'S MAIDEN NAME Docia Gurganus		16. SOCIAL SECURITY NO. 243-22-2951	
17. INFORMANT Ms. Dianne Harbison, daughter, same as pt.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory failure</u> 1830 DUE TO, OR AS A CONSEQUENCE OF (b) <u>OVARIAN CANCER</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>3 years</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Immediate	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>JANUARY 11, 1978</u> , to <u>AUGUST 3, 1981</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>AUGUST 3, 1981</u> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Gino Clement Bottino</u>		DEGREE M.D.		22c. DATE SIGNED 8/5/81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Gino C. Bottino, M.D.		22e. ADDRESS NATIONAL INSTITUTES OF HEALTH CLINICAL CENTER, BETHESDA, MD 20205			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 08-08-81		23c. NAME OF CEMETERY OR CREMATORY Family Cemetery	
23d. LOCATION CITY OR TOWN COUNTY STATE Richlands, North Carolina		24. FUNERAL DIRECTOR NAME Hines/Rinaldi Funeral Home, Inc.		25. REGISTRY AUG 10 1981	
11800 New Hampshire Ave, Silver Spring, Md.					



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITH THE COPIES AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 21648	
1. DECEASED NAME (TYPE OR PRINT) Arthur Charles Gehring						7a. DATE KNOWN OF DEATH		MONTH DAY YEAR		21. HOUR MIN. SEC.	
3. SEX M						4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR Sept 25 16		6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ohio						7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		7c. DATE PRONOUNCED DEAD Aug 14 1981	
10. CITY OR TOWN OF DEATH Sil. Spg.						11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sligo Creek Park way		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Programs Officer		12b. KIND OF BUSINESS OR INDUSTRY Navy Dept.	
13a. STATE MD						13b. COUNTY Montg		13c. CITY OR TOWN Sil. Spg		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Charles Gehring						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Minerva Wass					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes						(IF YES, GIVE WAR OR DATES) WWII		16b. SOCIAL SECURITY NO. 289-03-5174		17. INFORMANT wife ADDRESS same as 13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Dis. DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) Chronic Myocardial Dis. DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: None											
19a. DATE OF OPERATION None						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH						21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>						21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE John S. Rogers						TITLE (SPECIFY) M.D.		MEDICAL EXAMINER		DATE SIGNED Aug 14 1981	
EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers, M.D.						ADDRESS _____					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation				23b. DATE Aug. 17, 1981		23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory				23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria Virginia	
24. FUNERAL DIRECTOR NAME Francis J. Collins						25a. DATE REC'D. BY REGISTRAR AUG 18 1981					
500 University Blvd., W. Silver Spring, Md.						REGISTRAR'S SIGNATURE James J. [Signature]					

(5)

1. The first part of the paper is devoted to a discussion of the general principles of the theory of the structure of the atom. It is shown that the theory of the structure of the atom is a special case of the more general theory of the structure of the molecule.

2. The second part of the paper is devoted to a discussion of the general principles of the theory of the structure of the molecule. It is shown that the theory of the structure of the molecule is a special case of the more general theory of the structure of the crystal.

3. The third part of the paper is devoted to a discussion of the general principles of the theory of the structure of the crystal. It is shown that the theory of the structure of the crystal is a special case of the more general theory of the structure of the solid.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 2 1 6 4 9

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Marion R. Geiger			2a. DATE OF DEATH MONTH DAY YEAR August 4, 1981		2b. HOUR 5 P.M.
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Aug. 16, 1921	6. AGE (IN YEARS LAST BIRTHDAY) 59 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Mass.	7b. CITIZEN OF WHAT COUNTRY? US	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.		
10. CITY OR TOWN OF DEATH Chevy Chase	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 5011 Westport Rd.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker	12b. KIND OF BUSINESS OR INDUSTRY Home	
13a. STATE Md.	13b. COUNTY Montgomery	13c. CITY OR TOWN Chevy Chase	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 5011 Westport Rd.	
14. FATHER'S NAME FIRST MIDDLE LAST Michael J. Reidy	15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Marion Howard		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		
16b. SOCIAL SECURITY NO. 018-18-9225		17. INFORMANT Gerald L. Geiger Same as Item # 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>metastatic Carcinoma</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>carcinoma of the Breast</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Months</u> <u>years</u> <u>years</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) <u>(the hospital)</u> attended the deceased from <u>8-3</u> , 19 <u>81</u> , to <u>8-4</u> , 19 <u>81</u> , that (I) <u>(we)</u> lost saw the deceased alive on <u>above</u> , <u>(we)</u> <u>(did)</u> <u>(did not)</u> view the body after death.					
22b. SIGNATURE <u>Russell W. Tilley, M.D.</u>		DEGREE <u>M.D.</u>		22c. DATE SIGNED <u>8-4-81</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Russell W. Tilley, M.D.		22e. ADDRESS <u>4701 - Mass. Ave. N.W.</u> <u>Washington, D.C. 20016</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 8/6/81	23c. NAME OF CEMETERY OR CREMATORY Culpeper Nat'l. Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Culpeper Va.	
24. FUNERAL DIRECTOR NAME ADDRESS		25a. DATE REC'D. BY REGISTRAR AUG 7 1981			
		25b. REGISTRAR'S SIGNATURE <u>Russell W. Tilley</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR					REG. NO. 8121650						
1. DECEASED NAME (TYPE OR PRINT) Ralph P. Gibson					7a. DATE OF DEATH MONTH DAY YEAR 8/8/81						
1. SEX MALE		1. RACE CAUCASIAN		1. DATE OF BIRTH MONTH DAY YEAR NOV 18, 1893		1. AGE (IN YEARS LAST BIRTHDAY) 87 YES			7b. HOUR 12:14 PM		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		1. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		1. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.					
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION Shady Grove Adventist Hosp				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ELECTRICAL AND HOME IMPROVEMENTS		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE MARYLAND					13b. COUNTY MONTGOMERY		13c. CITY OR TOWN GAITHERSBURG		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST GEORGE G. GIBSON					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST EMMA M. HAMILTON						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 577-50-6165		17. INFORMANT ADDRESS BERNIECE V. GIBSON SAME AS 13 WIFE							
18. CAUSE OF DEATH Enter only one cause per line (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 4920 IMMEDIATE CAUSE (a) Respiratory Crisis DUE TO, OR AS A CONSEQUENCE OF (b) COPD DUE TO, OR AS A CONSEQUENCE OF (c) Emphysema PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Smokers										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day yours yours	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (the hospital) attended the deceased from 8/5/81 to 8/8/81, that (I) (we) saw the deceased alive on 8/5/81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (each) (did not) view the body after death.										22c. DATE SIGNED 8/8/81	
22b. SIGNATURE Thos G. Ward		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Thos G. Ward		22e. ADDRESS 6116 Robinwood Bethesda, Md.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 8/11/81		23c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE BRENTWOOD PRI GEO MD.					
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS				24b. ADDRESS 500 UNIV. BLVD., W., SILVER SPRING, MD. 20902		25a. DATE REC'D. BY REGISTRAR AUG 12 1981					
25b. REGISTRAR'S SIGNATURE Francis J. Collins											

MEDICAL CERTIFICATION

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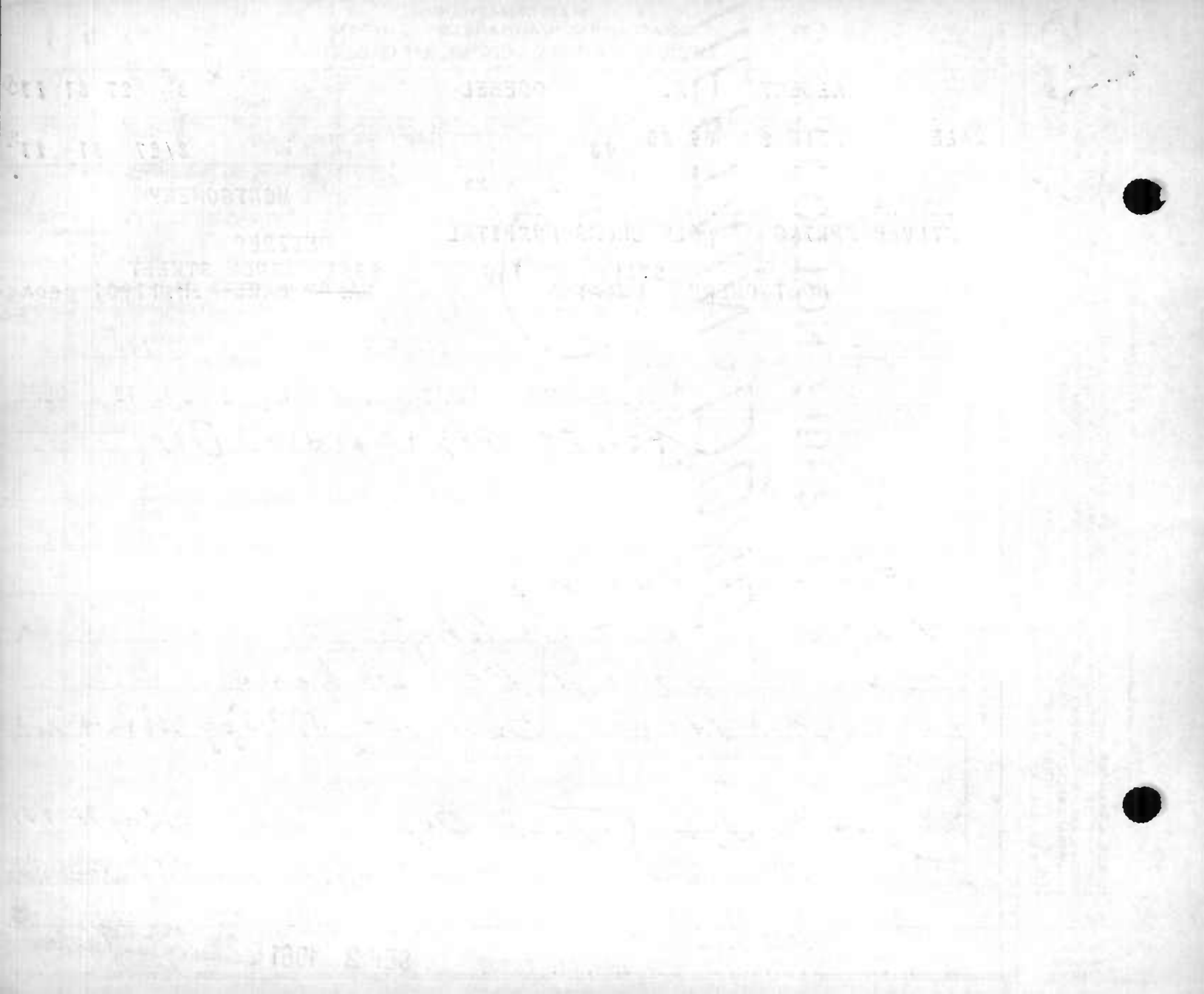
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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY. PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 21651	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ALBERT K. GOEBEL										2a. DATE KNOWN OF DEATH MONTH DAY YEAR 8 27 81	
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YRS. 2 09 89	6. AGE (IN YEARS) (LAST BIRTHDAY) 98 YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 8/27 81		2b. HOUR 11:30 M			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) INDIANA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD					
10. CITY OR TOWN OF DEATH SILVER SPRING		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUBURBAN, GIVE STREET ADDRESS) HOLY CROSS HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED		12b. KIND OF BUSINESS OR INDUSTRY U.S. GOVT			
13a. STATE MD										13b. COUNTY MONTGOMERY	
14. FATHER'S NAME FIRST MIDDLE LAST FREDERICK GOEBEL										15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARGARET KRAFT	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 214-36-2810			17. INFORMANT LILLIAN E. GOEBEL			ADDRESS SAME AS 13 WIFE		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Dis</u> 4291 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <u>Fracture left hip</u>											
19a. DATE OF OPERATION 7-20-81			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? Fracture L hip						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 0212 1981			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Fell at home					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Home			21i. LOCATION STREET Darrow St.			21j. LOCATION CITY OR TOWN COUNTY STATE Silver Spg Mont MD		
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <i>[Signature]</i>						TITLE (SPECIFY) M.D. <i>[Signature]</i>			DATE SIGNED Aug 28/90		
EXAMINER'S NAME (TYPE OR PRINT) JOHN S. ROGERS						ADDRESS 1919 SEMINARY ROAD, SILVER SPRING, MD.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 8/31/81		23c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN			23d. LOCATION CITY OR TOWN COUNTY STATE SILVER SPRING MONT MD			
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS						25a. DATE REC'D. BY REGISTRAR SEP 2 1981			25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>		



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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 21652

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Ann YETTA Goldberg		2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 8 24 1981		2b. HOUR M 7:33
3. SEX female	4. RACE white	5. DATE OF BIRTH MONTH DAY YEAR 2 01 40	6. AGE (IN YEARS LAST BIRTHDAY) 41 YRS.	7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN. 0 0 0 0
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENNSYLVANIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County		10. CITY OR TOWN OF DEATH Olney		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery General Hospital
12. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Marketing Research		13. KIND OF BUSINESS OR INDUSTRY RESEARCH		
14. FATHER'S NAME FIRST MIDDLE LAST MORRIS COHEN		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST SOPHIE FAIGENBAUM		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. ---		17. INFORMANT (Husband) ADDRESS LOUIS GOLDBERG 16905 Old Colony Way Rockville, MD.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 4292 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
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PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).		
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion	
ACTUAL SIGNATURE H.R. Swain EXAMINER'S NAME (TYPE OR PRINT) Hormez R. Guard, M.D.	TITLE (SPECIFY) Assistant MEDICAL EXAMINER DATE SIGNED 8/25/81
ADDRESS 111 Penn Street, Balto., MD 21201	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE AUG. 27, 81	23c. NAME OF CEMETERY OR CREMATORY KING DAVID MEM. GARDEN	23d. LOCATION CITY OR TOWN COUNTY STATE FALLS CHURCH VA.
24. FUNERAL DIRECTOR NAME DANZANSKY-GOLDBERG ADDRESS ROCKVILLE, MD.		25. DATE REC'D. BY REGISTRAR AUG 31 1981	
MEMORIAL CHAPELS, INC 1170 ROCKVILLE PIKE		26. REGISTRAR'S SIGNATURE Hormez R. Guard	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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Handwritten signature or initials.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The certificate may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1 - STATE REGISTRAR		REG. NO. 8121653							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Ethel Goldman						2a. DATE OF DEATH MONTH DAY YEAR August 2, 1981		2b. HOUR a 12:35 M	
3 SEX Female		4 RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Oct 5 1898		6. AGE (IN YEARS LAST BIRTHDAY) YRS 82		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Poland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Monty. MD.			
10. CITY OR TOWN OF DEATH Wheaton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Randolph Hills N. H.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Dressmaker		12b. KIND OF BUSINESS OR INDUSTRY Clothing	
13a. STATE Maryland		13b. COUNTY Monty		13c. CITY OR TOWN Wheaton		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 4011 Randolph Road	
14. FATHER'S NAME FIRST MIDDLE LAST Lazer unk Goldman		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST unknown							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 577-10-5811		17. INFORMANT ADDRESS Frances G. Wasser 5120-33rd St. Wash. DC					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) arteriosclerotic cardiovascular disease 4292 DUE TO, OR AS A CONSEQUENCE OF disease Conditions, if any, which gave rise to immediate cause (a): stating the underlying cause last (b) _____ (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 yrs.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				19c. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		19d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		20c. HOW INJURY OCCURRED: (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)					
21a. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21c. LOCATION STREET CITY OR TOWN COUNTY STATE					
22. I certify that (I) this hospital attended the deceased from 8/20/81 to 8/21/81 ; that (I) saw the deceased die on 8/21/81 , and that in my opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.									
22a. SIGNATURE B. N. ROSENBAUM, M.D.		DEGREE M.D.				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8/21/81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) B. N. ROSENBAUM		ADDRESS 3720 FARRAGUT AVE. KENNESINGTON, MD. 20895							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE Aug.		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Sutland, PG. Maryland			
24. FUNERAL DIRECTOR NAME W. W. Chambers Co, Inc		ADDRESS 8655 Ga. Ave. S.S.		25a. DATE REC'D BY REGISTRAR AUG 26 1981		25b. REGISTRAR'S SIGNATURE <i>Francis J. ...</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. **Page 1** may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, **Page 3** should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 10 days of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 1 2 1 6 5 4			
1 - FOR STATE REGISTRAR				CERTIFICATE OF DEATH			
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH			
FIRST MIDDLE LAST MAUDE C GOODWIN				MONTH DAY YEAR 8/21/81			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 7 31 05		6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penn.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY Co., MD.	
10. CITY OR TOWN OF DEATH SILVER SPRING		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hosp.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md.		13b. COUNTY Mont.		13c. CITY OR TOWN S.S.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST George S. Copelin		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sarah J. Straw		13e. STREET ADDRESS 12500 Davan Drive			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 215 46 3488		17. INFORMANT ADDRESS William Goodwin (Husband) Same as above			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Degenerative Pulmonary Disease</u> 4960 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>8/21</u> , 19 <u>80</u> , to <u>8/21</u> , 19 <u>81</u> , that (I) (we) last saw the deceased alive on <u>8/21</u> , 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE MARIC H. ELG, M.D.				DEGREE		22c. DATE SIGNED 8/21/81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS 9801 Goya Ave. Silver Spring, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/25/81		23c. NAME OF CEMETERY OR CREMATORY Arlington Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Arlington, Va.	
24. FUNERAL DIRECTOR NAME Hines/Rinaldi F.H. 11800 N.H. Ave. S.S. Md.				25. RECEIVED BY REGISTRAR DATE OF REGISTRATION AUG 25 1981			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 48 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) HELEN M. GORMAN			2a. DATE OF DEATH 8 Month 24 Day 81 Year			2b. HOUR 9A						
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH July 29, 1929		6. AGE (In years last birthday) 52 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		IF UNDER 24 HRS. HOURS MIN		
7a. BIRTHPLACE (State or foreign country) PENNSYLVANIA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.						
10. CITY OR TOWN OF DEATH Takoma Park.		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 9908 Carroll Ave.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) SECRETARY				12b. KIND OF BUSINESS OR INDUSTRY CIA govt.				
13a. USUAL RESIDENCE (Where deceased lived in institution: Residence before admission) STATE MARYLAND		13b. COUNTY PRINCE GEORGES		13c. CITY OR TOWN HYATTSVILLE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 7333 NEW HAMPSHIRE AVENUE				
14. FATHER'S NAME First Middle Last JAMES A. GORMAN			15. MOTHER'S MAIDEN NAME First Middle Last ANNA T. GIVENS									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) NO		16b. SOCIAL SECURITY NO. 579-40-4839		17. INFORMANT BROTHER		Address HYATTSVILLE, MD.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 1749 IMMEDIATE CAUSE (a) Carcinoma breast, with metastases DUE TO, OR AS A CONSEQUENCE OF to lungs, liver, bone Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH undet-		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) None.												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If injury, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from 7/1 , 19 81 , to Aug 24 , 19 81 , that (I) (we) last saw the deceased alive on 8/14 , 19 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE John J. Sweeney MD					DEGREE MD		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 8/24/81			
22d. PHYSICIAN'S NAME (Type) John J. Sweeney MD					22e. ADDRESS 1905 Gatewood Place							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 8/27/81		23c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN			23d. LOCATION (City or Town) (County) (State) SILVER SPRING MONT MD.					
24. FUNERAL DIRECTOR FRANCIS J. COLLINS					ADDRESS 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901		25a. REC'D BY REGISTRAR AUG 25 1981		25b. REGISTRAR'S SIGNATURE [Signature]			

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 1 21656	
1. DECEASED NAME (TYPE OR PRINT) FIRST MARY MIDDLE Helen LAST Green										2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 1981 Aug 20 11 30 AM	
3. SEX F	4. RACE BLACK	5. DATE OF BIRTH MONTH DAY YEAR 10 34 47 YRS.		6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD 1981 Aug 20 11 30 AM		2b. HOUR		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) ALABAMA.		7b. CITIZEN OF WHAT COUNTRY? U.S. A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.				
10. CITY OR TOWN OF DEATH Tak Park		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Wash Advent Hosp				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
13a. STATE Md.		13b. COUNTY Prince Georges		13c. CITY OR TOWN Tak Park		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 7611 Maple Ave Apt. 703			
14. FATHER'S NAME FIRST THOMAS MIDDLE BEASLEY LAST					15. MOTHER'S MAIDEN NAME FIRST MARY MIDDLE Fields LAST						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 217-32-4733		17. INFORMANT ADDRESS LISIAN Green (husband) SAME AS # 13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Failure 9509 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) Overdose, Digitalis and Valium DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: None											
19a. DATE OF OPERATION None				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 8 20 1981		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Took overdose digitalis, valium					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Home		21f. LOCATION STREET Maple Ave. CITY OR TOWN Tak Park COUNTY Prince Georges STATE Md.					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE [Signature]						TITLE (SPECIFY) M.D. Dr. [Signature]		DATE SIGNED 1981 Aug 21			
EXAMINER'S NAME (TYPE OR PRINT) ADDRESS											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 8-25-81		23c. NAME OF CEMETERY OR CREMATORY Md. Nat'l Mem. Park				23d. LOCATION CITY OR TOWN LAUREL COUNTY PR Geo. Md.			
24. FUNERAL DIRECTOR NAME George R. Snowden ADDRESS 246 N. Wash. St. Rockville, Md. 20850				25a. DATE REC'D. BY REGISTRAR AUG 25 1981		25b. REGISTRAR'S SIGNATURE [Signature]					



Item #5 per phone call w/Run... Home STATE OF MARYLAND
 8/24/81 rc DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 1 2 1 6 5 7
 1- STATE REGISTRAR Item #13a-13e Film 9559 8/3/81 rc CERTIFICATE OF DEATH

1. DECEASED NAME FIRST MIDDLE LAST MARSHALL R. GREER			2a. DATE OF DEATH MONTH DAY YEAR 8/12/81		2b. HOUR 4:30 A.M.	
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Mar 1, 1896		6. AGE (IN YEARS LAST BIRTHDAY) 85		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.C.	7b. CITIZEN OF WHAT COUNTRY? US	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.		
10. CITY OR TOWN OF DEATH Bethesda	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fernwood Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) V/Admiral		12b. KIND OF BUSINESS OR INDUSTRY U.S. Navy	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 30a. STATE D.C. 30b. COUNTY Montgomery 30c. CITY OR TOWN Bethesda		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1705 34th St. N.W. 6530 Democracy Blvd.		
14. FATHER'S NAME FIRST MIDDLE LAST George W. Greer		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST (Unknown)				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. WW II 578-50-6569		17. INFORMANT ADDRESS Marshall Greer, Jr. 5206 Falmouth Ct. Beth. Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease 4140 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Arteriosclerotic Cerebrovascular Disease						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 7/17/81 to 8/12/81 , that (I) (we) lost saw the deceased alive on 7/17/81 , and that (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE Stanley M. Silverberg		22c. DATE SIGNED 8/12/81		22d. PHYSICIAN'S NAME (TYPE OR PRINT) Stanley M. Silverberg, M.D.		
22e. ADDRESS 5530 Wisconsin Ave., N.W. Washington, D.C.		22f. MEDICAL PHYSICIAN <input checked="" type="checkbox"/> ATTENDING PHYSICIAN <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/17/81		23c. NAME OF CEMETERY OR CREMATORY Arlington National Cem. Arlington, Va.		
23d. LOCATION CITY OR TOWN COUNTY STATE		24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc. NAME ADDRESS 5130 Wisc. Ave. N.W. Wash., D.C.				
25a. DATE REC'D. BY REGISTRAR AUG 17 1981		25b. REGISTRAR'S SIGNATURE James J. [Signature]				

10/10/81
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Item #13c Film G558 8/17/81 rc

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 2 1 6 5 8

FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) CHARLES M. GRIMM			2a. DATE OF DEATH MONTH DAY YEAR 8-4-81		2b. HOUR 744 AM
3. SEX Male	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR June 28, 1897		6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ohio	7b. CITIZEN OF WHAT COUNTRY? United States	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD	
10. CITY OR TOWN OF DEATH Bethesda	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Manager	12b. KIND OF BUSINESS OR INDUSTRY General Motors	
13a. STATE Maryland		13b. CITY OR TOWN Prince Georges		13c. STREET ADDRESS 4609 29th Street #4	
14. FATHER'S NAME FIRST MIDDLE LAST Charles S. Grimm		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Grace M. Mentel			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes WW I		16b. SOCIAL SECURITY NO. 216-03-1370		17. INFORMANT Mary G. Winningham ADDRESS 4701 Willard Ave. Chevy Chase, MD	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO, OR AS A CONSEQUENCE OF (b) Pulmonary Embolism Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days 20 yrs					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: Diaphragmatic ulcer with bleeding; melanoma of neck					
19a. DATE OF OPERATION 29		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Diaphragmatic ulcer with bleeding; melanoma of neck		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from SEPT 15, 1975 to AUG 4, 1981 , that (I) (we) last saw the deceased alive on AUG 3, 1981 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Stephen W. Dejer M.D.		DEGREE M.D.		22c. DATE SIGNED 8-4-81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) STEPHEN W. DEJER, M.D.		22e. ADDRESS 6719 WILSON LA, BETHESDA, MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE August 7, 1981		23c. NAME OF CEMETERY OR CREMATORY Woodland Cemetery	
23d. LOCATION CITY OR TOWN COUNTY STATE Dayton, Ohio		23e. DATE REC'D. BY REGISTRAR AUG 7 1981			
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey		FIRM Homes, P.A. Bethesda, Maryland		25a. REGISTRAR'S SIGNATURE Thomas J. ...	

1- FOR
STATE
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) MORA R. GUTEKUNST			2a DATE OF DEATH MONTH DAY YEAR AUGUST 13, 1981			2b HOUR 8:05 P.M.			
3 SEX Female		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR Nov. 27 1904		6 AGE (IN YEARS LAST BIRTHDAY) 76 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Michigan		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10 CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hospital				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Teacher		12b KIND OF BUSINESS OR INDUSTRY Education	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md. 13b. COUNTY Montgomery 13c. CITY OR TOWN Gaithersburg					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 401 Russell Ave. #609		
14 FATHER'S NAME FIRST MIDDLE LAST Schuyler - Raber					15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emily R. Carles				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b SOCIAL SECURITY NO. 212-40-1220A		17 INFORMANT ADDRESS Walter G. Gutekunst 401 Russell Ave. #609 Gaithersburg, Md. 20877				
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) RENAL FAILURE 1889 DUE TO, OR AS A CONSEQUENCE OF (b) METASTATIC BLADDER CARCINOMA DUE TO, OR AS A CONSEQUENCE OF (c) 5 MONTHS.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 WEEKS.	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE				
22a I certify that (I) (this hospital) attended the deceased from JULY 31, 1981 to AUGUST 13, 1981 , that (I) (we) lost saw the deceased alive on AUG. 12, 1981 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE Eugene P. Flannery MD					DEGREE MD			22c DATE SIGNED AUG 13 1981	
22d PHYSICIAN'S NAME (TYPE OR PRINT) EUGENE P. FLANNERY, MD					22e ADDRESS 18111 PRINCE PHILIP DRIVE OLNEY, MARYLAND 20832				
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b DATE Aug. 14, '81		23c NAME OF CEMETERY OR CREMATORY Lee's Crematory		23d LOCATION CITY OR TOWN COUNTY STATE Washington, D.C.		
24 FUNERAL DIRECTOR Gartner Sandison F.H.					316 E. Diamond Ave., Gaithersburg, Md. 20877		25a DATE REC'D. BY REGISTRAR AUG 18 1981		
25b REGISTRAR'S SIGNATURE Paul J. Smith									

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Nov. 21 1941
Washington
Mr. Tolson
Mr. E. A. Tamm
Mr. Clegg
Mr. Glavin
Mr. Ladd
Mr. Nichols
Mr. Rosen
Mr. Tracy
Mr. Carson
Mr. Egan
Mr. Gurnea
Mr. Hendon
Mr. Pennington
Mr. Quinn
Mr. Nease
Miss Gandy

Dear Sir:

Enclosed for you are two copies of a letterhead memorandum from the Federal Bureau of Investigation to the Department of Justice, dated and captioned as above.

Very truly yours,
J. Edgar Hoover
Director

Approved: _____
Special Agent in Charge

Enclosure

Released
in
need of space

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

may be retained by the hospital or attending physician.
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.



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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8	1	2	1	6	6	0	
CERTIFICATE OF DEATH										REG. NO.							
1. DECEASED NAME (TYPE OR PRINT) <i>Roger T Hall</i>										2a. DATE OF DEATH MONTH DAY YEAR <i>8-4-81</i> 2b. HOUR <i>1:30 A.M.</i>							
3. SEX Male			4. RACE Caucasian			5. DATE OF BIRTH MONTH DAY YEAR July 21, 1898			6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS.			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Massachusetts			7b. CITIZEN OF WHAT COUNTRY? United States			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery</i> MD								
10. CITY OR TOWN OF DEATH <i>Bethesda</i>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Suburban Hospital</i>							12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Engineer			12b. KIND OF BUSINESS OR INDUSTRY Construction				
13a. STATE Maryland			13b. COUNTY Montgomery			13c. CITY OR TOWN Cabin John			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 7992 Riverside Drive						
14. FATHER'S NAME FIRST MIDDLE LAST Edwin C. Hall					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bertha Smith												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II			17. INFORMANT Frances Hall			ADDRESS Same as 13								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>from negative Sepsis</i> 2168 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <i>Ruptured viscus</i> (c) <i>Retroperitoneal Tumor Histocytoma</i> DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>24 h</i> <i>24 h</i> <i>18 mo</i>																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:																	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from <i>4/80</i> , 19____, to <i>8/3/81</i> , 19____, that (I) (we) last saw the deceased alive on <i>8/3/81</i> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE <i>Jeremy V. Cooke</i> MD 22c. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Jeremy V. Cooke</i>										DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <i>8/4/81</i>	
22d. ADDRESS <i>16466 Conn. Ave. Kensington</i>																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation				23b. DATE August 5, 1981		23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory				23d. LOCATION CITY OR TOWN STATE Alexandria, Virginia							
24. FUNERAL DIRECTOR NAME ADDRESS Robert A. Pumphrey Funeral Homes, P.A. Bethesda, Maryland										25a. DATE REC'D. BY REGISTRAR AUG 7 1981			25b. REGISTRAR'S SIGNATURE <i>Thomas J. ...</i>				

State Cancellation July 31, 1968

San Francisco United States

Construction Engineer Hospital

Residing Montgomery Carlo John X 1991 Riverside Drive

Marina C. Hall Bertha Suite

Yes NW 11 578-01-4714 Francisco Hall Anne Smith

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Construction 5, 1961 Robert A. Thompson Funeral Home, P.A. Bethesda, Maryland

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed in the office of the health officer with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 1 2 1 6 6 1	
1. FOR STATE REGISTRAR		REG. NO.									
1. DECEASED NAME (TYPE OR PRINT) Milmo Ann Hambleton					2a. DATE OF DEATH MONTH DAY YEAR August 26, 1981			2b. HOUR 4:45 A			
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Feb. 7, 1934		6. AGE (IN YEARS LAST BIRTHDAY) 47 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Delaware		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD.					
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Clinical Center (NIH)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Agent-Extension Serv. Program		12b. KIND OF BUSINESS OR INDUSTRY 4 H			
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Potomac		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 11816 Enid Drive 20854			
14. FATHER'S NAME FIRST MIDDLE LAST Pierce A. Fox				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nedra Whitsel							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 221- 20-3074		17. INFORMANT ADDRESS (same as above) Mr. Neal Hambleton (husband)							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Sepsis with multiple infarctions including pulmonary lower lobes bilaterally, right kidney DUE TO, OR AS A CONSEQUENCE OF (b) Mitral stenosis status post mitral valve replacement DUE TO, OR AS A CONSEQUENCE OF (c) replacment									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 week 7 years		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from July 26, 19 81 , to Aug. 26, 19 81 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Aug. 26, 19 81 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above <input checked="" type="checkbox"/> (we) did <input checked="" type="checkbox"/> (we) did not view the body after death.											
22b. SIGNATURE <i>Catherine A. Picken</i>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 8/27/81			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) CATHERINE A. PICKEN				22e. ADDRESS National Institutes of Health Clinical Center, Bethesda, Md, 20205							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE August 29, 1981		23c. NAME OF CEMETERY OR CREMATORY Old Drewyers Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Odesa Delaware					
24. FUNERAL DIRECTOR NAME ADDRESS ROBERT A. PUMPHREY FUNERAL HOMES P/A 300 W. MONTGOMERY AVE., ROCKVILLE, MD. 20850				25a. DATE REC'D. BY REGISTRAR SEP 4 1981		25b. REGISTRAR'S SIGNATURE <i>Thomas Van Nostrand</i>					

4:30

United States
Post-Office
Department

United States
Post-Office
Department

United States
Post-Office
Department

United States
Post-Office
Department

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-copiers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				81 21662			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) GEORGE R. HAMILTON				2a. DATE OF DEATH MONTH DAY YEAR 08 22 81 2b. HOUR 10:49A			
3. SEX Male.		4. RACE White.		5. DATE OF BIRTH MONTH DAY YEAR Jan. 3, 1891		6. AGE (IN YEARS LAST BIRTHDAY) 90 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York.		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.	
10. CITY OR TOWN OF DEATH SILVER SPRING		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOLY CROSS		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired, Poultryman.		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland.				13b. COUNTY Silver Spring.		13c. CITY OR TOWN Silver Spring.	
14. FATHER'S NAME FIRST MIDDLE LAST Alexander Hamilton.				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Stimpson.			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes.		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATE) W. W. # 1 578-12-6664		17. INFORMANT ADDRESS 10123 Dallas Ave. S. S. Md. Mrs. Marine Hamilton.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH weeks
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. Arteriosclerotic Heart Disease, Heart Block, Pacemaker							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (in this hospital) attended the deceased from we Aug 22, 1981 to Aug 22, 1981 that I saw the deceased alive on Aug 22, 1981 , and that (my) opinion death occurred on the date and hour and from the causes stated above. (If I did not view the body after death)							
22b. SIGNATURE Pat Kellogg MD / Steve Jones MD				DEGREE MD		22c. DATE SIGNED 8/24/81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Kellogg				22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Aug. 25, 1981		23c. NAME OF CEMETERY OR CREMATORY Parklawn.		23d. LOCATION CITY OR TOWN COUNTY STATE Silver Sprg. Montg. Md.	
24a. DATE REC'D. BY REGISTRAR AUG 25 1981				24b. REGISTRAR'S SIGNATURE John J. [Signature]			
25a. DATE REC'D. BY REGISTRAR AUG 25 1981				25b. REGISTRAR'S SIGNATURE John J. [Signature]			



New York, N. Y.

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New York, N. Y.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.		
1. FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		
			FIRST MIDDLE LAST <i>Mattie Alice Harper</i>		MONTH DAY YEAR HOUR <i>8-25-81 12⁰⁰ P M</i>		
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>Mar. 14, 1931</i>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. <i>50</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Franklin</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery</i> MD.	
10. CITY OR TOWN OF DEATH <i>Takoma Park</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Washington Adventist Hosp.</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Accounting Clerk</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Giant Foods</i>	
13a. STATE <i>Maryland</i>		13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>College Park</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS <i>9707 52nd Avenue</i>		14. FATHER'S NAME FIRST MIDDLE LAST <i>Horace E. Lambert</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Edna Jane Hartman</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. <i>579-42-1780</i>		17. INFORMANT ADDRESS <i>David L. Harper/Canton, Maryland</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Intestinal obstruction</i> <i>1539</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Metastatic Colon Cancer</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>1539</i> DUE TO, OR AS A CONSEQUENCE OF						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 weeks</i> <i>6 months</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <i>Gastrointestinal Bleeding</i>							
19a. DATE OF OPERATION <i>25 Aug</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Intestinal obstruction</i>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>15 May 1981</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <i>7676 New Hampshire Ave Laurelley Park MD</i>			
22a. I certify that (I) (this hospital) attended the deceased from <i>15 May 1981</i> to <i>25 Aug 1981</i> , that I (we) lost saw the deceased alive on <i>25 Aug 1981</i> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I/we) (did/did not) view the body after death.							
22b. SIGNATURE <i>Thomas A. Beusinger</i>		DEGREE <i>MD</i>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>8/26/81</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Thomas A. Beusinger</i>		22e. ADDRESS <i>7676 New Hampshire Ave Laurelley Park MD</i>		23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>Aug. 28, 1981</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill Cemetery</i>		23d. LOCATION CITY OR TOWN COUNTY <i>Franklin, Pendleton W. Va.</i>		24. FUNERAL DIRECTOR NAME <i>Capitol Funeral Service</i>		25. DATE REC'D. BY REGISTRAR (25) REGISTRAR'S SIGNATURE <i>SEP 3 1981</i>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8121664	
1. DECEASED NAME (TYPE OR PRINT) SARA KATHERINE HARRINGTON					2a. DATE OF DEATH MONTH DAY YEAR AUGUST 27, 1981			2b. HOUR 3:00 ^P M			
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR JAN 21, 1924		6. AGE (IN YEARS LAST BIRTHDAY) 57 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MICHIGAN		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD.					
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE CLINICAL CENTER, NIH				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) TEACHER		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE CALIFORNIA		13b. COUNTY ✓		13c. CITY OR TOWN OAKLAND		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1986 GOULDIN RD 94611			
14. FATHER'S NAME FIRST MIDDLE LAST NICK DIGAETANO				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST SOPHIE ROBBINS							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 386-12-2243		17. INFORMANT MR. WESLEY F. HARRINGTON (NOK)		ADDRESS SAME AS ABOVE					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SUBDIAPHRAGMATIC ABSCESS 1570 DUE TO, OR AS A CONSEQUENCE OF (b) ASPIRATION PNEUMONIA, ADENOCARCINOMA HEAD OF DUE TO, OR AS A CONSEQUENCE OF (c) PANCREAS, STATUS POST-PANCREATECTOMY									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (this hospital) attended the deceased from AUGUST 4, 1981, to AUGUST 27, 1981, that (we) last saw the deceased alive on AUGUST 27, 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (did not) view the body after death.											
22b. SIGNATURE 				DEGREE MD				22c. DATE SIGNED 8/28/81			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DAVID M. HYAMS, MD				22e. ADDRESS NATIONAL INSTITUTES OF HEALTH CLINICAL CENTER, BETHESDA, MARYLAND 20205							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE 8-31-81		23c. NAME OF CEMETERY OR CREMATORY METROPOLITAN CEM.		23d. LOCATION CITY OR TOWN COUNTY STATE ALEXANDRIA, VA					
24. FUNERAL DIRECTOR NAME VANN AND WILLIAMS 4804 GA., AVE., N. W.				25a. RECEIVED BY REGISTRAR SEP 3 1981		25b. REGISTRAR'S SIGNATURE 					

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

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FOR
1. STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Mary LOUISE Hartman			2a. DATE OF DEATH MONTH DAY YEAR 8/31/81		2b. HOUR 10:55 PM
3. SEX Female	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR 09 19 19		6. AGE (IN YEARS LAST BIRTHDAY) 61 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW YORK	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD	
10. CITY OR TOWN OF DEATH Rockville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Shady Grove Adventist Hosp		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired DEFENCE INTELL AGENCY		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE MD	13b. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13c. STREET ADDRESS 13 SUNNYMEADE COURT X299 X764 X16 X78 X29			
14. FATHER'S NAME FIRST MIDDLE LAST THOMAS J. HEAVEY		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ANNA MAY McALLISTER			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO	16b. SOCIAL SECURITY NO. 577-48-8913	17. INFORMANT ADDRESS MARY H. PEARELLI SAME AS 13 DAUGHTER			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Cardiogenic shockAPPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH**4100**
Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last

DUE TO, OR AS A CONSEQUENCE OF

(b) **Acute myocardial infarction**

DUE TO, OR AS A CONSEQUENCE OF

(c) **severe coronary art disease**

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Diabetes mellitus

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from Aug 30 , 19 81 , to Aug 31 , 19 81 , that (I) (we) lost saw the deceased alive on Aug 31 , 19 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE Mary Fang, MD	DEGREE	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 9/1/81
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Mary Fang		22e. ADDRESS 11004 Roundtable Ct, Rockville, MD	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 9/4/81	23c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL	23d. LOCATION CITY OR TOWN COUNTY STATE ARLINGTON VIRGINIA
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS		25a. DATE REC'D. BY REGISTRAR SEP 8 1981	
500 UNIV. BLVD., W., SILVER SPRING, MARYLAND 20901		REGISTRAR'S SIGNATURE Francis J. Collins	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

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1. FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) HOWARD S. HEID			2a. DATE OF DEATH MONTH DAY YEAR August 23, 1981			2b. HOUR 5:15 AM			
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR March 12, 1904		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD.			
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Potomac Valley Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retailer		12b. KIND OF BUSINESS OR INDUSTRY Furniture	
13a. STATE Maryland			13b. COUNTY Montgomery		13c. CITY OR TOWN Bethesda		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Benjamin Heid			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Teressa Schwab			13e. STREET ADDRESS 5225 Pooks Hill Road			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <input type="checkbox"/> (IF YES, GIVE WAR OR DATES) No			16b. SOCIAL SECURITY NO. 578-01-6113		17. INFORMANT ADDRESS Ida N. Heid (Same as 13e) Wife				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) GENERALIZED METASTATIC 1850 } DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. CARCINOMA OF PROSTATE (b) } (c) } PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from FEB. 27 19 81 , to AUG. 23 19 81 , that (I) (we) last saw the deceased alive on JULY 27 19 81 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE R.C. Daddario M.D.					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 8/23/81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ROBERT C. DADDARIO					22e. ADDRESS 5413 CEDAR LANE, BETHESDA				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) ENTOMBMENT			23b. DATE August 25, 1981		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Mausoleum		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood Maryland		
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Homes, P.A., Rockville, Maryland					25a. DATE REC'D. BY REGISTRAR AUG 31 1981				
25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

August 2, 1964

Very Truly Yours,

Director

Mr. J. Edgar Hoover

Washington, D. C.

Mr. J. Edgar Hoover

Director, FBI

Washington, D. C.

Dear Mr. Hoover:

Reference is made to your letter of July 29, 1964, regarding the above captioned matter.

Enclosed

are

two

copies

of a letterhead memorandum dated and captioned as above.

Very truly yours,
Special Agent in Charge

Enclosure

Very truly yours,
Special Agent in Charge

Very truly yours,
Special Agent in Charge

Very truly yours,
Special Agent in Charge

Very truly yours,
Special Agent in Charge

Very truly yours,

Very truly yours,

Very truly yours,

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 21667	
1. DECEASED NAME (TYPE OR PRINT) Carl Richard Hellman						2b. DATE KNOWN OF DEATH ESTIMATED MONTH DAY YEAR 8 7 19 81		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 8 7 19 81		2d. HOUR 11:08 P.M.	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR June 13, 1965		6. AGE (IN YEARS LAST BIRTHDAY) 16 YRS.		7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 8 7 19 81	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland				7b. CITIZEN OF WHAT COUNTRY? United States				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.	
10. CITY OR TOWN OF DEATH Bethesda				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Student		12b. KIND OF BUSINESS OR INDUSTRY Education	
13a. STATE Maryland						13b. CITY OR TOWN Montgomery		13c. CITY OR TOWN Potomac		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Marshall Hellmann						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mollie Young					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 900 02 9127		17. INFORMANT ADDRESS Marshall Hellmann Same as 13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 8136 Cranio-cerebral trauma DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR MIN. MONTH DAY YEAR 9:45 P.M. 8 7 1981		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) bicyclist struck by auto					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) roadway		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 2200 Block Tuckerman Lane Bethesda Montgomery Maryland					
22a. I certify that I took charge of the remains described above, held an autopsy <input checked="" type="checkbox"/> inspection <input type="checkbox"/> inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <i>Thomas D. Smith</i>				TITLE (SPECIFY) Deputy Chief				DATE SIGNED 8/9/81			
EXAMINER'S NAME (TYPE OR PRINT) Thomas D. Smith, M.D.				ADDRESS 111 Penn Street, Baltimore, MD. 21201							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE August 11, 1981		23c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Washington, D.C.			
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Homes, P.A.				ADDRESS Bethesda, Maryland		25a. DATE REC'D. BY REGISTRAR AUG 14 1981		25b. REGISTRAR'S SIGNATURE <i>James J. Martin</i>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

DHMH-16 50M 1/81
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Pauline C. Helsel			2a. DATE OF DEATH MONTH DAY YEAR 8 28 45		2b. HOUR 4:55 A M
3. SEX F	4. RACE Cauc	5. DATE OF BIRTH MONTH DAY YEAR 9 15 23	6. AGE (IN YEARS LAST BIRTHDAY) 57	7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, DC	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.		
10. CITY OR TOWN OF DEATH Silver Spr.	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3109 Helsel Drive		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife	12b. KIND OF BUSINESS OR INDUSTRY own home	
13a. STATE Maryland		13b. COUNTY Montgomery	13c. CITY OR TOWN Sil. Spring	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 3109 Helsel Drive,
14. FATHER'S NAME FIRST MIDDLE LAST Franklin P. Clark			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Marion L. Bickel		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) --	17. INFORMANT ADDRESS Janice Suit -dau- Rockv. Md. 20852		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 1619 MALNUTRITION DUE TO, OR AS A CONSEQUENCE OF (b) METASTATIC DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) CARCINOMA OF LARYNX					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 wks 1 yr 1 1/2 yr.
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION ---		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED ---		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR --- P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) ---		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) ---	21f. LOCATION STREET ---	CITY OR TOWN ---	COUNTY ---
22a. I certify that (1) (this hospital) attended the deceased from AUG 9 , 19 71 , to AUG 2 , 19 81 , that (1) (we) last saw the deceased living above (above) (died) (did not view the body after death).					
22b. SIGNATURE John B. Nason, MD		DEGREE ---		22c. DATE SIGNED 8-3-81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOHN B. NASON, MD		22e. ADDRESS 800 Pershing Dr. S. S., Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 8-4-1981	23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven		23d. LOCATION CITY OR TOWN Sil. Spr. Montgomery	STATE Md
24. FUNERAL HOME NAME Warner E. Pumphrey, Inc.		ADDRESS 8434 Ga. Ave., S.S. Md.		25a. DATE REC'D. BY REGISTRAR AUG 5 1981	25b. REGISTRAR'S SIGNATURE James J. Nason

MEDICAL CERTIFICATION

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EXHIBIT OF EVIDENCE
IN THE CASE OF
MELVIN WHITE

1961
1962

THE STATE OF TEXAS
COUNTY OF DALLAS
I, JAMES E. WHITE, do hereby certify that the foregoing is a true and correct copy of the original as the same appears in the files of the Dallas County Jail.

[Signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove card number 1 and 2 should be filed within 24 hours of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other trauma, the medical examiner must be notified of the death.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8	1	2	1	6	6	9
1. FOR STATE REGISTRAR										REG. NO.						
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST John Henderson Mary G. Henderson										2a. DATE OF DEATH MONTH DAY YEAR 8-24-81				2b. HOUR 12:50 PM		
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 8-3-94		6. AGE (IN YEARS LAST BIRTHDAY) YRS. 87		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.								
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Scotland		7b. CITIZEN OF WHAT COUNTRY? England		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.										
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) housewife		12b. KIND OF BUSINESS OR INDUSTRY home								
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE 13c. CITY OR TOWN 13d. INSIDE CITY LIMITS? Maryland Montgomery Silver Spring YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										13e. STREET ADDRESS 13007 Wilton Oaks Dr.						
14. FATHER'S NAME FIRST MIDDLE LAST Thomas Robertson McPherson					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Agnes Ross											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) --		17. INFORMANT James D. Henderson		ADDRESS same as 13e										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-Respiratory Arrest 4392 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Congestive Heart Failure (c) Anteroseptal Coronary Artery Disease years										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 11 Days						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.																
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)												
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE												
22a. I certify that (1) (this hospital) attended the deceased from Aug. 13, 1981, to Aug. 24, 1981, that (1) (we) last saw the deceased alive on Aug. 21, 1981, and that in my (our) opinion death occurred on the date and hour and from the causes stated above (1) (I did not view the body after death).										22b. SIGNATURE Benjamin Aronson MD		22c. DATE SIGNED 8-24-81				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Benjamin Aronson MD										22e. ADDRESS 3720 Farnsworth Ave. New Md.						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 8/25/81		23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria, Virginia										
24. FUNERAL DIRECTOR NAME Tyson Wheeler Funeral Home, Inc. 1331 Rockville Pike Rockville, Maryland										25a. DATE REC'D. BY REGISTRAR AUG 26 1981						

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM FM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 21670	
1. DECEASED NAME (TYPE OR PRINT) ALMA HIERS										2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 08 12 19 81	
3. SEX female 4. RACE black 5. DATE OF BIRTH MONTH DAY YEAR 06 29 17 6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS. 7. CITIZEN OF WHAT COUNTRY? U.S.A. 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										2b. HOUR 9:39a	
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY) South Carolina 10. CITY OR TOWN OF DEATH Takoma Park 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hospital 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife 12b. KIND OF BUSINESS OR INDUSTRY										2c. DATE PRONOUNCED DEAD 08 12 19 81 2d. HOUR 9:39a	
13a. STATE MD 13b. COUNTY Prince George's 13c. CITY OR TOWN Seat Pleasant 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS Chapel Oaks, Md. 1405 Early Oaks Ln.										9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.	
14. FATHER'S NAME FIRST MIDDLE LAST Eugene Pauls 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Viola Carters											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no (IF YES, GIVE WAR OR DATES) 16b. SOCIAL SECURITY NO. 577-30-7980 17. INFORMANT Bernard Hiers ADDRESS 1405 Early Oaks Lane Chapel Oaks, Maryland											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Dis. 4391 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) (c) DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). Carcinoma of Esophagus & Metastases											
19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 P.M. 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) 21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE John Rogers, MD TITLE (SPECIFY) M.D. MEDICAL EXAMINER DATE SIGNED Aug 12/1981											
EXAMINER'S NAME (TYPE OR PRINT) John Rogers, MD ADDRESS											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial 23b. DATE Aug 18, 1981 23c. NAME OF CEMETERY OR CREMATORY Harmony Memorial Park 23d. LOCATION CITY OR TOWN COUNTY STATE Landover Prince George's MD											
24. FUNERAL DIRECTOR NAME ROLLINS FUNERAL HOME, INC. ADDRESS 4339 HUNT PLACE, N. E. WASHINGTON, D. C. 20019 25a. DATE REC'D. BY REGISTRAR AUG 20 1981 25b. REGISTRAR'S SIGNATURE											

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Taken Park Washington Adventist Hospital

Send Pleasant

1003 Early Oak Ln.

Montgomery County

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08 12 81 9:30a

[Faint, illegible handwritten notes and signatures at the bottom of the page]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		REG. NO.				8 1 2 1 6 7 1			
1 DECEASED NAME (TYPE OR PRINT) DOROTHY I. MIDDLE		LAST HIGGINS		2a DATE OF DEATH MONTH DAY YEAR 8/25/81		2b HOUR 9:05 AM			
3 SEX FEMALE		4 RACE WHITE		5 DATE OF BIRTH MONTH DAY YEAR FEB. 8, 1892		6 AGE (IN YEARS LAST BIRTHDAY) 89 YRS.		7 UNDER 1 YEAR MONTHS DAYS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Mass.		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10 CITY OR TOWN OF DEATH Gaithersburg		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Herman Wilson Health Care Center		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Librarian		12b KIND OF BUSINESS OR INDUSTRY Library of Congress			
13a STATE Maryland		13b COUNTY Mont.		13c CITY OR TOWN Gaithersburg		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS 301 Russell Ave.	
14 FATHER'S NAME FIRST MIDDLE LAST James W. Higgins		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Addie I. Leonard		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b SOCIAL SECURITY NO. 215-44-7394		17 INFORMANT ADDRESS Velma M. Fraley Derwood, Md.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Senility 7970 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Years									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (I) (this hospital) attended the deceased from 8-23 19 81 , to 8-25 19 81 , that (I) (was) last saw the deceased alive on 8-23 19 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE Jack Schumacher DEGREE M.D.				22c DATE SIGNED 8-25-81		22d PHYSICIAN'S NAME (TYPE OR PRINT) Jack Schumacher			
22e ADDRESS Russell Ave Gaithersburg, Md.									
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE Aug. 27, 1981		23c NAME OF CEMETERY OR CREMATORY Laytonsville		23d LOCATION CITY OR TOWN COUNTY STATE Laytonsville Mont. Md.			
24 FUNERAL DIRECTOR FRANCIS H. BARBER-LAYTONSVILLE, MD. 20879				25a DATE RECD. BY REGISTRAR AUG 31 1981		25b REGISTRAR'S SIGNATURE Francis H. Barber			

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8/25/81

10/25/81

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10/25/81

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove contents of pages 1 and 2 and file within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic incident, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				REG. NO. 8121672			
1. FOR STATE REGISTRAR							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Lena Hiller				2a. DATE OF DEATH MONTH DAY YEAR 08 21 81			
3 SEX Female		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR unknown 1895		6 AGE (IN YEARS LAST BIRTHDAY) 86 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Russia		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10 CITY OR TOWN OF DEATH Olney		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY -----	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN Maryland Montgomery Sil Spg.				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 107-11 Glenhaven Road	
14 FATHER'S NAME FIRST MIDDLE LAST Samuel (unknown)				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rebecca (unknown)			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. unknown		17 INFORMANT ADDRESS 10711 Glenhaven Rd, Sil Spg., Md. Gertrude Frankeberger			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY (a) 4292 Cardiac Dysrhythmias, uncontrollable DUE TO, OR AS A CONSEQUENCE OF (b) Electrolyte and Metabolic disturbance DUE TO, OR AS A CONSEQUENCE OF (c) Atherosclerotic cardiovascular disease						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Marked renal insufficiency; Diabetes Mellitus							
19a. DATE OF OPERATION 8/20/81		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Gangrene of foot		20a. AUTOPSY YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 6/30 , 19 81 , to 8/21 , 19 81 , that (I) was lost saw the deceased alive on 8/20 , 19 81 , and that in (my) their opinion death occurred on the date and hour and from the causes stated above. (I) we (did) (did not) view the body after death.							
22b. SIGNATURE Sol Shear				DEGREE M.D.		22c. DATE SIGNED 8/21/81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SOL SHEAR				22e. ADDRESS 18711 PRINCE PHILIP Dr. OLNEY, Md. 20821.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8-23-81		23c. NAME OF CEMETERY OR CREMATORY Beth David Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Elmont, L.I., New York	
24. FUNERAL DIRECTOR NAME ADDRESS Danzansky-Goldberg Chapels; 1170 Rockville Pike				25a. DATE REC'D. BY REGISTRAR AUG 24 1981			
				25b. REGISTRAR'S SIGNATURE [Signature]			

MEDICAL CERTIFICATION

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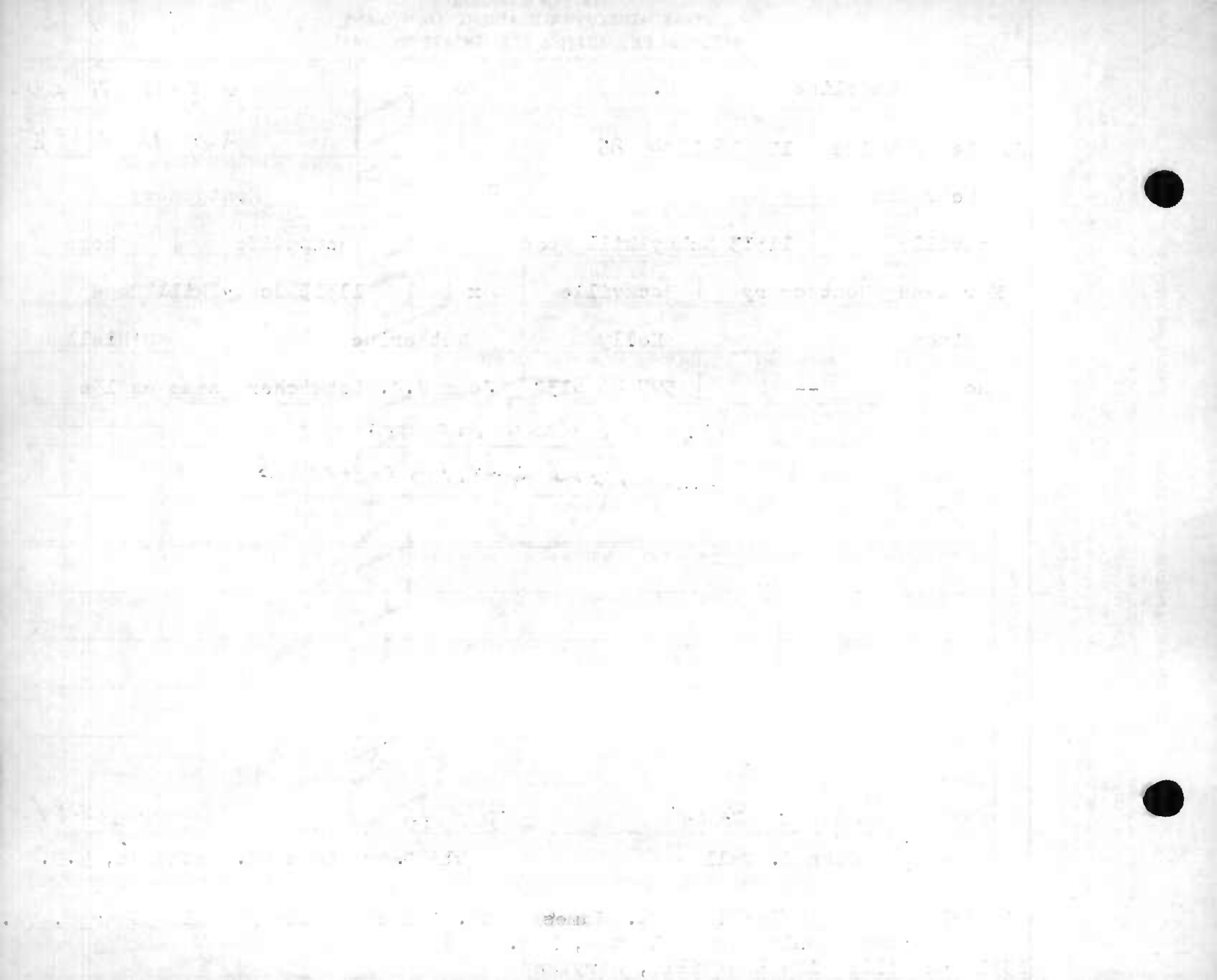
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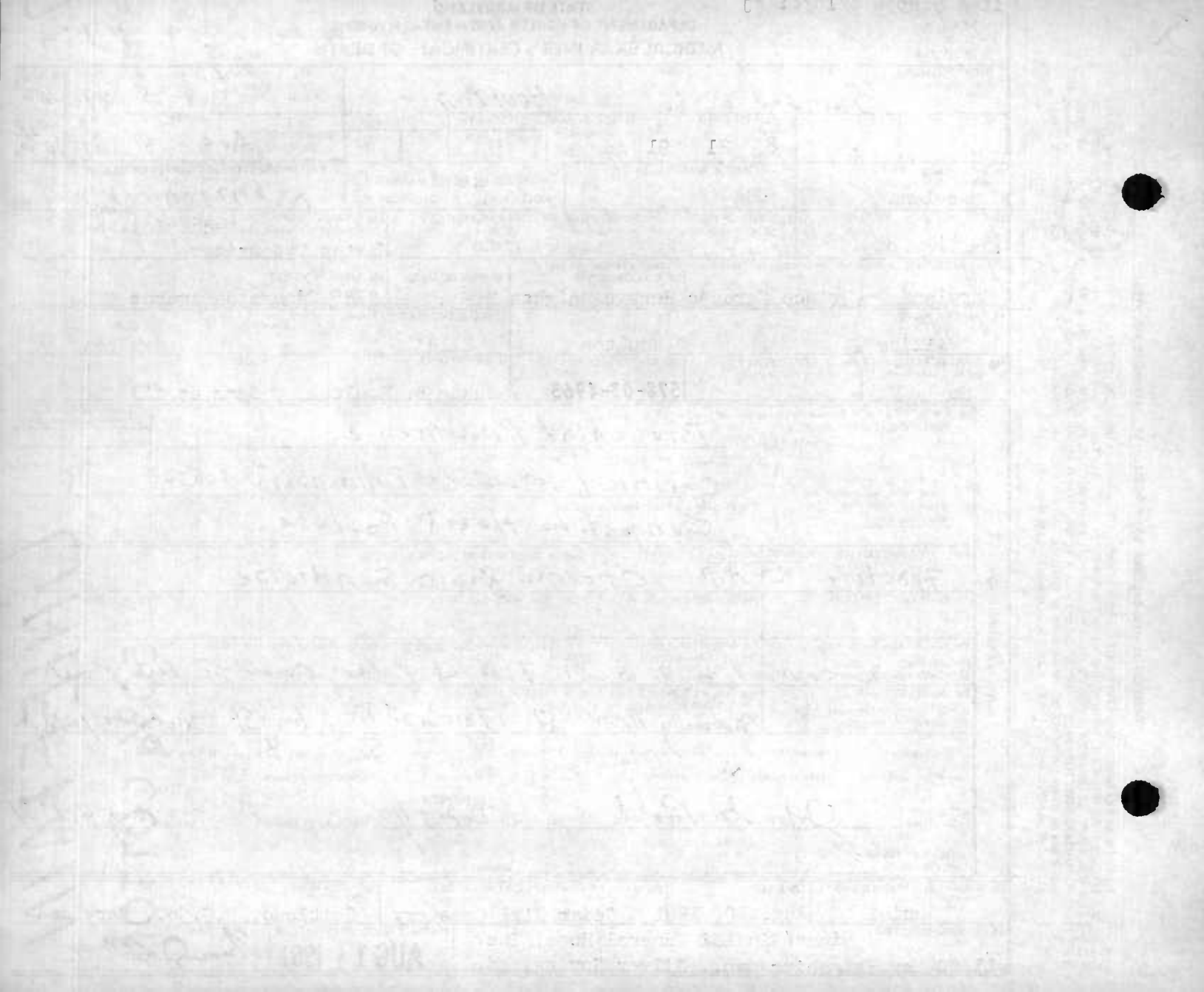
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 21673	
1- STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) Madeline K. Hodges										2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> 8-12-81 MONTH DAY YEAR	
3 SEX female 4 RACE white 5. DATE OF BIRTH MONTH DAY YEAR 11 16 1894 6 AGE (IN YEARS LAST BIRTHDAY) 86 YRS. IF UNDER 1 YR. MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.										2b. HOUR AM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Nebraska 7b. CITIZEN OF WHAT COUNTRY? USA 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>										2c. DATE PRONOUNCED DEAD Aug 12 1981 MONTH DAY YEAR	
10. CITY OR TOWN OF DEATH Rockville 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 11313 Schuylkill Road										9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife 12b. KIND OF BUSINESS OR INDUSTRY home											
13a. STATE Maryland 13b. COUNTY Montgomery 13c. CITY OR TOWN Rockville 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS 11313 Schuylkill Road											
14. FATHER'S NAME FIRST MIDDLE LAST Simon Kelly 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Katherine O'Niell											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no 16b. SOCIAL SECURITY NO. 577 86 8132 17. INFORMANT ADDRESS John V.R. Lebkicher same as 13e											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 4292 IMMEDIATE CAUSE (a) Cardio-Vascular Disease Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) Generalized Arteriosclerosis (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH										21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK										21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE John G. Ball TITLE (SPECIFY) Deputy MEDICAL EXAMINER DATE SIGNED Aug 12-81											
EXAMINER'S NAME (TYPE OR PRINT) John G. Ball ADDRESS Old Georgetown Rd. Bethesda, M.D.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial 23b. DATE 8/14/81 23c. NAME OF CEMETERY OR CREMATORY St. James Cath. Church Cemetery 23d. LOCATION CITY OR TOWN COUNTY STATE Falls Church, Va.											
24. FUNERAL DIRECTOR NAME Tyson Wheeler Funeral Home, Inc. ADDRESS 1331 Rockville Pike Rockville, Maryland 25. DATE REC'D BY REGISTRAR AUG 14 1981 REGISTRAR'S SIGNATURE											



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DEATH IS SUSPECTED, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE JUDICIAL OFFICER. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN A COPY OF THIS FILE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 21674															
1. DECEASED NAME (TYPE OR PRINT) Samuel L. Houlton												2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> 8-5-81		2b. HOUR 10:28 PM													
3. SEX M		4. RACE W		5. DATE OF BIRTH MONTH 8 DAY 21 YEAR 91		6. AGE (IN YEARS) LAST BIRTHDAY 89 YRS.		IF UNDER 1 YR. MONTHS 0 DAYS 0		IF UNDER 24 HRS. HOURS 0 MIN. 0		2c. DATE PRONOUNCED DEAD Aug 5 1981		2d. HOUR 10:28 PM													
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.															
10. CITY OR TOWN OF DEATH Bethesda				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Master Typewriter				12b. KIND OF BUSINESS OR INDUSTRY															
13a. STATE Maryland				13b. COUNTY Prince Georges				13c. CITY OR TOWN Berwyn Heights				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS 8736 Edmonston Avenue											
14. FATHER'S NAME FIRST William MIDDLE Houlton LAST Houlton						15. MOTHER'S MAIDEN NAME FIRST Ella MIDDLE Houlton LAST Houlton						16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 578-03-4963				17. INFORMANT Graham B. Houlton				ADDRESS Same as #13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchial Pneumonia - 4280 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) Chronic Obstructive Pulmonary Disease. DUE TO, OR AS A CONSEQUENCE OF (c) Congestive Heart Failure.														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). Fracture Rt Hip. Chronic Brain Syndrome																											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 7 am 8-3-81				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Fall out of bed caused fracture of hip.																			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Nursing Home				21f. LOCATION STREET 2101 Fairland Rd. CITY OR TOWN Silver Sp. COUNTY Montgomery STATE Md.																			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .																											
ACTUAL SIGNATURE John B. Ball				TITLE (SPECIFY) Deputy				MEDICAL EXAMINER				DATE SIGNED Aug 6, 1981															
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS																							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE Aug. 10, 1981				23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery				23d. LOCATION CITY OR TOWN Suitland, P.G.Co., Maryland COUNTY MARYLAND STATE MARYLAND															
24. FUNERAL DIRECTOR NAME Hines/Rinaldi Funeral Home, Inc.				25a. DATE REC'D. BY REGISTRAR AUG 11 1981				25b. REGISTRAR'S SIGNATURE James J. Ball																			
11800 New Hampshire Ave., Silver Spring, Md.																											



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 48 HOURS AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH - 17
(VR A15 ME (1))
15M 2/80

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. STATE REGISTRAR										21675									
1. DECEASED NAME (TYPE OR PRINT)										2a. DATE KNOWN OF DEATH									
FIRST MIDDLE LAST Wilbert James Huff										MONTH DAY YEAR HOUR 8/17 19 81									
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		2b. HOUR					
Male		White		MONTH DAY YEAR Oct. 4, 1890		LAST BIRTHDAY 90 YRS.		MONTHS DAYS		HOURS MIN.		MONTH DAY YEAR 8/17 19 81		11:00 A. M.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED				9. BALTIMORE CITY OR COUNTY OF DEATH							
Butler, Penna.				USA				NEVER MARRIED WIDOWED DIVORCED				Montgomery County MD.							
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY							
Silver Spring				15 Hill Top Road				Ret. Chemist				U.S. Govt.							
13a. STATE										13b. COUNTY									
Maryland										Montgomery									
14. FATHER'S NAME										15. MOTHER'S MAIDEN NAME									
FIRST MIDDLE LAST Leonidas Martin Huff										FIRST MIDDLE LAST Mary Ann Weidhas									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?										16b. SOCIAL SECURITY NO.									
yes (YES, NO, OR UNKNOWN)										WW 1 (IF YES, GIVE WAR OR DATES)									
217-36-9006										Rachel V. Huff-wife-(same as 13e)									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART I DEATH WAS CAUSED BY:														3 days					
IMMEDIATE CAUSE (a) <u>Bronchopneumonia.</u>																			
DUE TO, OR AS A CONSEQUENCE OF																			
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.																			
(b) _____																			
DUE TO, OR AS A CONSEQUENCE OF																			
(c) _____																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																			
Fracture of right hip.																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY?							
None												YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 8/4 19 81				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
								Fell at home.											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION											
Home				Hill Top Road, Silver Spring, Mont., Md.															
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																			
ACTUAL SIGNATURE				TITLE (SPECIFY)				DATE SIGNED											
John S. Rogers, M.D.				Deputy				8/17/81											
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS															
John S. Rogers, M.D.				1919 Seminary Road				Silver Spring, Montgomery, Md.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION									
Burial				8-19-81		North Cemetery				Butler Butler Penna.									
24. FUNERAL DIRECTOR																			
Warner E. Pumphrey, Inc.																			
8434 Ga. Ave., S.S. Md.																			
25a. DATE REC'D. BY REGISTRAR																			
AUG 19 1981																			
25b. REGISTRAR'S SIGNATURE																			
[Signature]																			

DHMH - 17
(VR A15 ME (1))
15M 2/80

BP _____
DHMH - 16 50M 1/81
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 30 days of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of the death.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE					8 1 2 1 6 7 6	
FOR 1 - STATE REGISTRAR					CERTIFICATE OF DEATH	
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH	
FIRST MIDDLE LAST Carole Marie Humke					MONTH DAY YEAR 8 14 81	
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 12 22 29		
6. AGE (IN YEARS LAST BIRTHDAY) 51 YRS		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.		10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY				
13a. STATE Maryland		13b. COUNTY Calvert		13c. CITY OR TOWN Huntingtown		
14. FATHER'S NAME FIRST MIDDLE LAST Rawley		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Hilda		16. ADDRESS 4020 Hidden Hill Drive Niner		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 579-36-4102		17. INFORMANT husband Clarence P. Humke same as 13		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiomyopathy</u> 1790 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Carcinoma</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Carcinoma of uterus</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Immediate 6 wks. 6 months	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: _____						
19a. DATE OF OPERATION Sept 7/1981		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Fibroid tumor obstruct		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE 8/14 81 8/14 81		
22a. I certify that (I) (this hospital) attended the deceased from <u>8/14</u> 19 <u>81</u> , to <u>8/14</u> 19 <u>81</u> , that (II) (we) lost saw the deceased alive on <u>8/14</u> 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (II) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <u>MEICHNER, MD.</u>				22c. DATE SIGNED 8/15/81		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MEICHNER, MD.				22e. ADDRESS 3915 Foxboro Dr. Wheat		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Aug. 19, 1981		23c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery		
23d. LOCATION CITY OR TOWN COUNTY STATE Washington, D.C.		24. FUNERAL DIRECTOR NAME Francis J. Collins		25a. DATE REC'D. BY REGISTRAR AUG 18 1981		
25b. REGISTRAR'S SIGNATURE <u>Francis J. Collins</u>						

RECEIVED
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U.S. AIR FORCE



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of office.

BP

DHMH - 16 50M 1/81
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8	1	2	1	6	7	7		
1- FOR STATE REGISTRAR										REG. NO.								
1. DECEASED NAME (TYPE OR PRINT) ANN C. Hurley										2a. DATE OF DEATH MONTH DAY YEAR 8/19/81							2b. HOUR 1:05 P.M.	
3. SEX Female			4. RACE CAUCASIAN			5. DATE OF BIRTH MONTH DAY YEAR 12-24-77			6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS.			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Vermont			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.									
10. CITY OR TOWN OF DEATH Rockville			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Collingswood Nursing Center							12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Arms. Dept. U.S. Govt			12b. KIND OF BUSINESS OR INDUSTRY					
13a. STATE —			13b. COUNTY —			13c. CITY OR TOWN WASH. DC.			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 4311 WINDOM PL N.W.							
14. FATHER'S NAME FIRST MIDDLE LAST JOHN CORNELIUS HURLEY					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY DOVOHUE													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO					16b. SOCIAL SECURITY NO. 577-60-2388					17. INFORMANT ADDRESS JOHN G. HURLEY 10247 BRIGADE DR FAIRFAX, VA								
18. CAUSE OF DEATH (Give only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: (a) IMMEDIATE CAUSE (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF Approx. 4 hrs. by coroner. Acute Myocardial Infarction. Coronary artery disease. 4 months.																		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)																		
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19					21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I, OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>					21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)					21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from Apr 19, 1981, to Aug 19, 1981, that (I) (we) lost saw the deceased alive on 7/25, 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.																		
22b. SIGNATURE James J. Foster M.D.										DEGREE			22c. DATE SIGNED 8/19/81					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JAMES J. FOSTER M.D.										22e. ADDRESS 916 19TH ST. NW WASH. D.C.								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial					23b. DATE 8-24-1981		23c. NAME OF CEMETERY OR CREMATORY ST. JOHN'S CEM.					23d. LOCATION CITY OR TOWN COUNTY STATE NORTHFIELD MONTGOMERY COUNTY MD.						
24. FUNERAL DIRECTOR NAME John F. DeVol										ADDRESS WASH. DC.			25a. DATE REC'D. BY REGISTRAR AUG 26 1981			REGISTRAR'S SIGNATURE James J. Foster		

MEDICAL CERTIFICATION

2

455

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 2 1 6 7 8

FOR
1- STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST: <i>Ella</i> MIDDLE: <i>XXXXXX</i> LAST: <i>Tager</i>			2a. DATE OF DEATH MONTH: <i>8</i> DAY: <i>14</i> YEAR: <i>81</i>		2b. HOUR <i>7:25</i> P.M.		
3. SEX <i>female</i>		4. RACE <i>white</i>		5. DATE OF BIRTH <i>March 13, 1889</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>92</i> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Virginia</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U S A</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery</i> MD.	
10. CITY OR TOWN OF DEATH <i>Olney</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Brooke Grove Nursing Home</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>own home</i>	
13a. STATE <i>Maryland</i>		13b. COUNTY <i>Carroll</i>		13c. CITY OR TOWN <i>Westminster</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST: <i>Thomas</i> MIDDLE: LAST: <i>Cornwell</i>		15. MOTHER'S MAIDEN NAME FIRST: <i>unknown</i> MIDDLE: LAST:		13e. STREET ADDRESS <i>136 Bertie Ave.</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. <i>212 24 3881</i>		17. INFORMANT <i>Eugene L. Payne Westminster Md. 21157</i>		ADDRESS <i>136 Bertie Ave.</i>	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CARDIAC FAILURE</i> 4409 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <i>Atherosclerosis</i> (c) <i>TERMINAL</i> YEARS							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>HYPERTENSION; SENILE DEMENTIA</i>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22. I certify that (I) (this hospital) attended the deceased from <i>4/17/81</i> 19 to <i>8/14</i> 19, that (I) (we) last saw the deceased alive on <i>2/28</i> 19 <i>81</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not re-view the body after death.							
27a. SIGNATURE <i>Donald R. Lewis</i>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		27b. DATE SIGNED <i>8/14/81</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>DONALD R. LEWIS</i>		22e. ADDRESS <i>OLNEY, MD 20832</i>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>8/17/81</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Ft. Lincoln Cemetery Brentwood Pr. Geo. Md.</i>		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR <i>Warner E. Pumphrey</i> 8434 Ga. Ave. Silver Spring, Md.		25a. DATE REC'D. BY REGISTRAR <i>AUG 18 1981</i>		25b. REGISTRAR'S SIGNATURE <i>James J. Harrison</i>			

1/2



CONFIDENTIAL

[Faint, mostly illegible text covering the majority of the page, appearing to be a memorandum or report.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 2 1 6 7 9

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) OTIS C. JERRELL			2a. DATE OF DEATH MONTH 8 DAY 25 YEAR 81			2b. HOUR 5:55 P.M.			
3. SEX Male		4. RACE white		5. DATE OF BIRTH MONTH 4 DAY 2 YEAR 00		6. AGE (IN YEARS (LAST BIRTHDAY)) 81		6. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) LEE Co. Va.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery Co. MD.			
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Collingswood Nursing Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Farmer		12b. KIND OF BUSINESS OR INDUSTRY Agriculture	
13a. STATE Md.		13b. COUNTY Montgomery		13c. CITY OR TOWN Gaithersburg		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 11920 Marmay Rd.	
14. FATHER'S NAME FIRST Unknown MIDDLE Jerrell LAST Jerrell				15. MOTHER'S MAIDEN NAME FIRST Molly MIDDLE Wagner LAST Wagner					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) -		17. INFORMANT Otis Jerrell, Jr.		ADDRESS 12000 Pindell School Rd. Fulton, Md. 20759			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adenocarcinoma of Prostate 1850 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 yrs	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Chronic brain syndrome with confusion									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from Jan 21 19 81 , to 25 Aug 19 81 , that (I) (we) lost saw the deceased alive on 21 Aug 19 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.									
22b. SIGNATURE Donald E. Dillon M.D.				DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 25 Aug 81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Donald E. Dillon, M.D.				22e. ADDRESS 18111 Pr. Philip Dr Olney, Md 20832					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/28/81		23c. NAME OF CEMETERY OR CREMATORY Forest Oak Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Gaithersburg Montgomery Md.			
24. FUNERAL DIRECTOR'S NAME Sp. Sandison		316 E. Diamond Ave., Gaithersburg, Md. 20877		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE James Van Notten			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 4 should be detached for use on the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

DHMH - 16 50M 7/77
(VR A 15 (4))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 2 1 6 8 0

FOR
1 - STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Kathryne E Jisi			2a. DATE OF DEATH MONTH DAY YEAR 8 1 81		2b. HOUR 2:50 M						
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 11 3 98		6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		7. IF UNDER 24 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY County MD.					
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Collingswood Nursing Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Home			
13a. STATE NEW York		13b. COUNTY Nassau		13c. CITY OR TOWN Floral Park		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 237 Plainfield Avenue			
14. FATHER'S NAME FIRST MIDDLE LAST Frederick Greenwald			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth MARTINSEN								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) NO			17. INFORMANT ADDRESS Grace James, daughter, Same as #13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intra-cranial hemorrhage 4140 DUE TO, OR AS A CONSEQUENCE OF (b) C.V.D. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Atherosclerosis, Genl APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 hours Years Years											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) A.S.H.D. & C.H.F., chronic											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 7-25 , 19 81 , to 8-1 , 19 81 , that (I) was last saw the deceased alive on 8-1 , 19 81 , and that in (my) best opinion death occurred on the date and hour and from the causes stated above, (I) was (did) view the body after death.											
22b. SIGNATURE Jack Schumacher M.D.				DEGREE M.D.				22c. DATE SIGNED 8-1-81			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jack Schumacher, M.D.				22e. ADDRESS 105 Russell Avenue Gaithersburg, Maryland							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE August 5, 1981		23c. NAME OF CEMETERY OR CREMATORY Flushing Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Flushing, Queens, New York			
24. FUNERAL DIRECTOR NAME ADDRESS Robert A. Pumphrey Funeral Homes, P.A. Bethesda, Maryland						25a. DATE REC'D. BY REGISTRAR AUG 5 1981		25b. REGISTRAR'S SIGNATURE James J. Smith			

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
1 - FOR STATE REGISTRAR		8 1 2 1 6 8 1 CERTIFICATE OF DEATH							
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH	
Nancy Bristol Johns								MONTH DAY YEAR AUGUST 8 81	
3 SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7b. HOUR	
Female		White		June 20, 1927		54		12:55 PM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		10. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
Washington, D.C.		USA				Montgomery			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Olney		Montgomery General Hospital		H. Wife		Home			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
Maryland		Mont.		Rockville		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		16500 Emory Lane	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
Hugh L. Buckingham		Margaret McQueen		no		220-26-2693		James S. Johns Same as #13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
1840		Radiation Colitis		Radiation Therapy		Carcinoma of vagina		weeks OCT 80 1980	
DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)		PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)		PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)		PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. LOCATION			
		HOUR A.M. MONTH DAY YEAR P.M. 19				STREET CITY OR TOWN COUNTY STATE			
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION		21g. LOCATION			
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				STREET CITY OR TOWN COUNTY STATE		STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE		DEGREE		22c. DATE SIGNED			
		J. Minarcuk		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		8/9/81			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		22f. ADDRESS		22g. ADDRESS			
J. Minarcuk, MD		Olney, Md. 20832		Olney, Md. 20832		Olney, Md. 20832			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION			
Burial		Aug. 11, 1981		Friends Cemetery		Sandy Spring, Mont. Md.			
24. FUNERAL DIRECTOR		24. FUNERAL DIRECTOR		24. FUNERAL DIRECTOR		24. FUNERAL DIRECTOR			
Francis H. Barber		Laytonsville, Md. 20879		Laytonsville, Md. 20879		Laytonsville, Md. 20879			
25. DATE REC'D. BY REGISTRAR		25. REGISTRAR'S SIGNATURE		25. REGISTRAR'S SIGNATURE		25. REGISTRAR'S SIGNATURE			
AUG 13 1981		AUG 13 1981		AUG 13 1981		AUG 13 1981			

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Volume

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Continued General Journal

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NOTICE

NOTICE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3a should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 1 2 1 6 8 2	
1- FOR STATE REGISTRAR				CERTIFICATE OF DEATH	
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH	
CLARENCE C Johnson				8/27/81 4:35A.M.	
3 SEX		4 RACE		5. DATE OF BIRTH	
MALE		NEGROID		MONTH DAY YEAR JUNE 12, 1939	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		6 AGE (IN YEARS LAST BIRTHDAY)	
VIRGINIA		U.S.A.		42 YRS.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		9 BALTIMORE CITY OR COUNTY OF DEATH	
TAKOMA PARK		WASHINGTON ADVENTIST HOSPITAL		MONTGOMERY MD	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		12c. STREET ADDRESS	
ADMINISTRATIVE		ASST. A.C.T. IO		418 BOYD AVENUE	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN	
MARYLAND		PRT. GEORGES		TAKOMA PARK	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	
CLARENCE W. JOHNSON		MARGARET JOHNSON		YES	
16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
537-40-6937		MARTHA A. JOHNSON		SAME AS 13 WIFE	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) Traumatic Hemorrhage				30 min	
2080 DUE TO, OR AS A CONSEQUENCE OF					
(b) Thrombocytopenia				2 weeks	
DUE TO, OR AS A CONSEQUENCE OF					
(c) Acute Leukemia				9 months	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
		P.M. 19			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION	
				CITY OR TOWN COUNTY STATE	
22a. I certify that (a) this hospital attended the deceased from 15 Dec 1980 to 27 Aug 1981, that (b) I lost saw the deceased alive on 26 Aug 1981, and that in my (a) opinion death occurred on the date and hour and from the causes stated above; (b) I did not view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
Thomas A. Bensinger		MD		8/27/81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
THOMAS A. BENNINGER MD		2276 New Hampshire Ave. Hyattsville, MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
BURIAL		8/31/81		FT. LINCOLN CEMETERY	
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
FRANCIS J. COLLINS		SEP 2 1981		Francis J. Collins	
500 UNIV. BLVD., W., SILVER SPRING, MD. 20901					

20

I have a few things to say
about the new book
which has just come out
of the press.

It is a very good book
and I think it will be
very useful to all who
are interested in the
subject. I have read it
and I think it is a very
good book. I have read it
and I think it is a very
good book. I have read it
and I think it is a very
good book.

Yours truly,
J. H. P.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrars, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and an autopsy required.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 1 2 1 5 8 3	
1. STATE REGISTRAR		REG. NO.									
1. DECEASED NAME (TYPE OR PRINT) Stanley R. Johnson STANLEY R. JOHNSON		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR		12:15 P.M.		
3. SEX m	4. RACE W	5. DATE OF BIRTH		MONTH	DAY	YEAR	6. AGE (IN YEARS LAST BIRTHDAY)		77 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) District of Col.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) stereotyper		12b. KIND OF BUSINESS OR INDUSTRY Wall St. Journal			
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOLY CROSS HOSPITAL		12c. STREET ADDRESS 11451 Lockwood Drive, apt # 103		13a. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13b. CITY OR TOWN Silver Spring			
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		14. FATHER'S NAME FIRST MIDDLE LAST Stanley R. Johnson		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Florence Tappen			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 578-09-9931A		17. INFORMANT Martha M. Johnson/wife/same as 13c		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION 44/4 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) SEPSIS, SA DUE TO, OR AS A CONSEQUENCE OF (c) Resection of abdominal aortic aneurysm		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH < 1 HOUR 5 DAYS 3 WEEKS			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): Renal failure; Hyperkalemia											
19a. DATE OF OPERATION 8/16/81		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Aortic bleeding; intestinal necrosis		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
21a. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21b. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)		21c. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21d. LOCATION STREET CITY OR TOWN COUNTY STATE		21e. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			
22a. I certify that (I) this hospital attended the deceased from 7/28 , 19 81 , to 8/20 , 19 81 , that (I) we lost saw the deceased alive on 8/20 , 19 81 , and that in (my) our opinion death occurred on the date and hour and from the causes stated above, (I) we (did) not view the body after death.											
22b. SIGNATURE Louis Kozloff		DEGREE		22c. DATE SIGNED 8/20/81		22d. PHYSICIAN'S NAME (TYPE OR PRINT) LOUIS KOZLOFF, M.D.		22e. ADDRESS 8218 WISCONSIN AVE. BETHESDA, MD. 20814			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8-22-81		23c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Washington D.C.		24. FUNERAL DIRECTOR NAME Hines/Rinaldi F.H.			
24. FUNERAL DIRECTOR NAME Hines/Rinaldi F.H.		24. FUNERAL DIRECTOR ADDRESS 11800 New Hampshire Ave Silver Spring, Md		25a. DATE REG'D. BY REGISTRAR AUG 25 1981		25b. REGISTRAR'S SIGNATURE [Signature]		25c. REGISTRAR'S NAME [Signature]			

14500 New Hampshire Ave
Silver Spring, Md
20901
Mr. T. Johnson
14500 New Hampshire Ave
Silver Spring, Md 20901

Mr. T. Johnson
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Silver Spring, Md 20901
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14500 New Hampshire Ave
Silver Spring, Md 20901

Mr. T. Johnson
14500 New Hampshire Ave
Silver Spring, Md 20901
Mr. T. Johnson
14500 New Hampshire Ave
Silver Spring, Md 20901



1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 2 1 6 8 4

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Leonora Kollas			2a. DATE OF DEATH MONTH DAY YEAR August 10, 1981		2b. HOUR 2:05 AM
3. SEX FEMALE	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR 11 26 20		6. AGE (IN YEARS LAST BIRTHDAY) 60	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE COUNTRY USA	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY CTY MD.	
10. CITY OR TOWN OF DEATH SILVER SPRING	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOLY CROSS HOSPITAL		12a. USUAL OCCUPATION (IF OTHER THAN HOUSEWIFE, GIVE WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE MARYLAND			13c. CITY OR TOWN SILVER SPRING		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST HENRY GROSSMAN			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST FANNIE ROSEN		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 131-03-5751		17. INFORMANT (HUSBAND) JACK JOLLES	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION 4100 DUE TO, OR AS A CONSEQUENCE OF: (b) HYPERTENSION Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c) Renal Failure PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Renal Failure			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2:05 AM		
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 7-29 , 19 81 , to 8-9 , 19 81 , that (I) (we) lost saw the deceased alive on 8-9 , 19 81 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Penny Bisk		DEGREE MD		22c. DATE SIGNED 8-10-81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) PENNY BISK		22e. ADDRESS 8630 FENTON ST SILVER SPRING			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE AUG. 11, 81		23c. NAME OF CEMETERY OR CREMATORY B'NAI ISRAEL CONGRE.	
23d. LOCATION CITY OR TOWN COUNTY STATE OXON HILL P.G. MD.		24. FUNERAL DIRECTOR NAME ADDRESS DANZANSKY-GOLDBERG CHAPELS 1170 ROCKVILLE PIKE ROCKVILLE, MD.			
25a. DATE REC'D. BY REGISTRAR AUG 13 1981		25b. REGISTRAR'S SIGNATURE [Signature]			

MEDICAL CERTIFICATION

99 68 35 50 1

2 9

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 4
To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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Lib

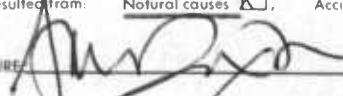
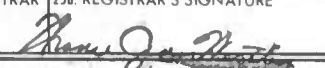
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

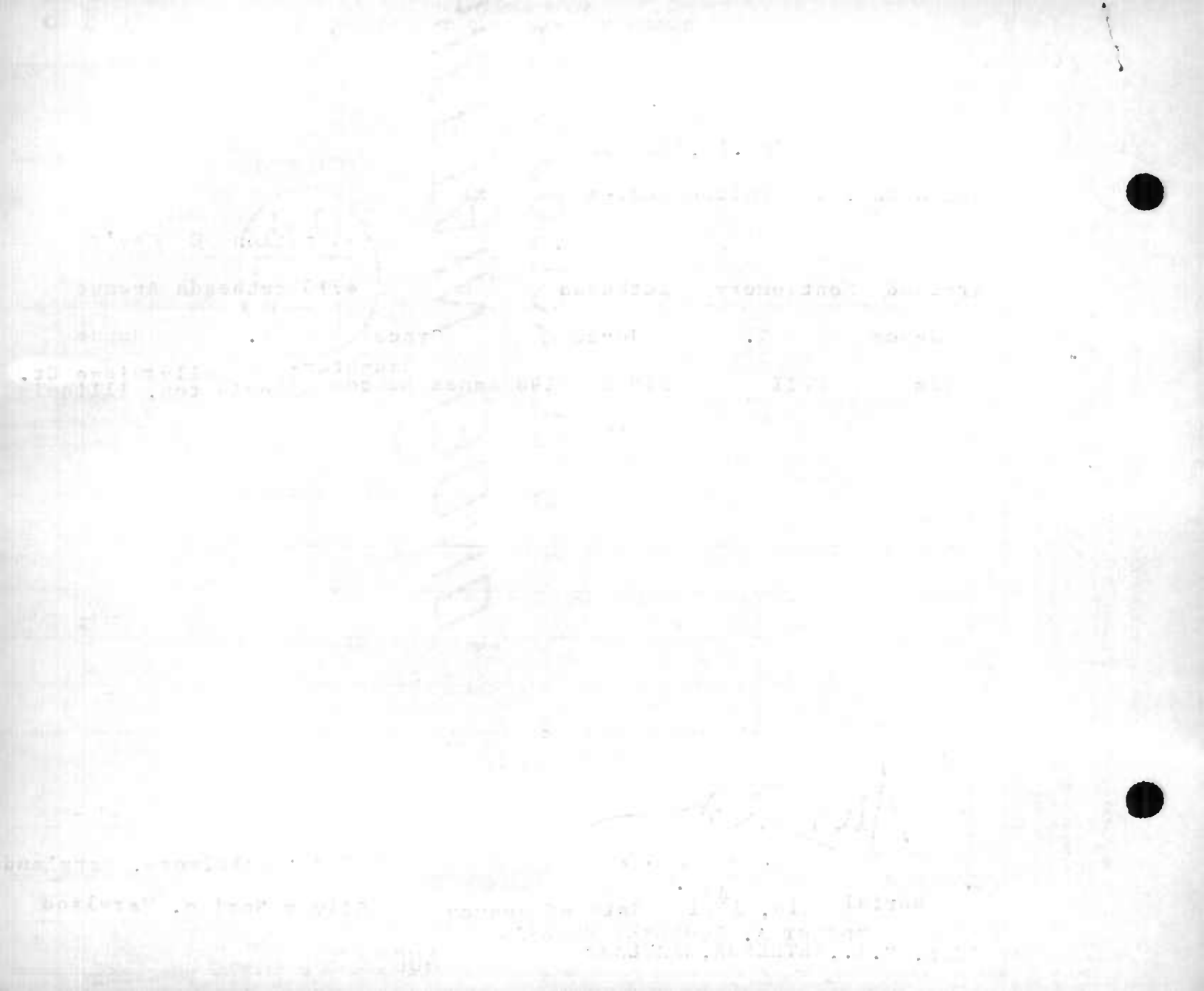
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 21685		
1- STATE REGISTRAR												
1. DECEASED NAME (TYPE OR PRINT) Jessie Florence Jordan										2a. DATE KNOWN OF DEATH <input type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <input type="checkbox"/> HOUR <input type="checkbox"/> MIN. Aug. 6, 1981		
3. SEX Female		4. RACE Cauc.		5. DATE OF BIRTH MONTH July DAY 29 YEAR 1904		6. AGE (IN YEARS) (LAST BIRTHDAY) 77 YRS.		IF UNDER 1 YR. MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>		IF UNDER 24 HRS. HOURS <input type="checkbox"/> MIN. <input type="checkbox"/>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia			7b. CITIZEN OF WHAT COUNTRY? United States			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD.			
10. CITY OR TOWN OF DEATH Bethesda			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4701 Glenbrook Parkway						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Office Manager		12b. KIND OF BUSINESS OR INDUSTRY Retail	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)												
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Bethesda		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 4701 Glenbrook Parkway				
14. FATHER'S NAME FIRST Franklin MIDDLE W. LAST Caton						15. MOTHER'S MAIDEN NAME FIRST Unknown MIDDLE LAST Stahl						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 214-26-7971		17. INFORMANT Same as item #13 ADDRESS Mr. Ralph P. Jordan, Husband						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular Disease - 4960 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) Obstructive Pulmonary Disease - (c) 										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)												
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .												
ACTUAL SIGNATURE John G. Ball				TITLE (SPECIFY) M.D. Dep'ty				DATE SIGNED Aug. 6, 1981				
EXAMINER'S NAME (TYPE OR PRINT) John G. Ball, M.D.				ADDRESS 7936 Old Georgetown Road Bethesda, Maryland								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation				23b. DATE Aug. 7, 1981		23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory, Alexandria, Virginia				23d. LOCATION CITY OR TOWN COUNTY STATE		
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey ADDRESS Homes, P.A., Bethesda, Maryland						25a. DATE REC'D. BY REGISTRAR AUG 12 1981		25b. REGISTRAR'S SIGNATURE James J. Ball				

BP

[Faint, illegible text and markings, possibly bleed-through from the reverse side of the page.]

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 21686	
1. DECEASED NAME (TYPE OR PRINT) GEORGE R. JOYCE										2a. DATE KNOWN OF DEATH MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <input checked="" type="checkbox"/> 8 12 1981	
3. SEX male		4. RACE white		5. DATE OF BIRTH MONTH Jan. DAY 13 YEAR 1925		6. AGE (IN YEARS) LAST BIRTHDAY 56 YRS.		IF UNDER 1 YR. MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/> HOURS <input type="checkbox"/> MIN. <input type="checkbox"/>		2b. HOUR M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, DC			7b. CITIZEN OF WHAT COUNTRY? United States			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County		
10. CITY OR TOWN OF DEATH Bethesda			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4710 Bethesda Ave.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Statistician DC			12b. KIND OF BUSINESS OR INDUSTRY Gov't	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE Maryland		13b. CITY OR TOWN Montgomery		13c. CITY OR TOWN Bethesda		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 4710 Bethesda Avenue			
14. FATHER'S NAME FIRST James MIDDLE R. LAST Joyce						15. MOTHER'S MAIDEN NAME FIRST Grace MIDDLE A. LAST Dunne					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes				16b. SOCIAL SECURITY NO. 579 26 8198		17. INFORMANT Daughter ADDRESS 1106 Hollyridge Cir. Agnes Hudson Bloomington, Illinois					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intestinal obstruction 5609 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 101.											
MEDICAL CERTIFICATION											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET " CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion TITLE (SPECIFY) Assistant MEDICAL EXAMINER DATE SIGNED 8-15-81											
ACTUAL SIGNATURE 				EXAMINER'S NAME Ann M. Dixon, M.D. ADDRESS 111 Penn St. Baltimore, Maryland							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE Aug. 18, 1981		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven				23d. LOCATION CITY OR TOWN Silver Spring COUNTY Maryland STATE Md.	
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY FUNERAL HOMES, P.A., BETHESDA, MARYLAND						25a. DATE REC'D. BY REGISTRAR AUG 24 1981		25b. REGISTRAR'S SIGNATURE 			



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 21687	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Alexander Karpinski										2a. DATE KNOWN OF DEATH MONTH DAY YEAR Aug 16 19 81	
3. SEX M	4. RACE W	5. DATE OF BIRTH MONTH DAY YEAR June 19 23	6. AGE (IN YEARS) LAST BIRTHDAY 58 YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7c. DATE PRONOUNCED DEAD MONTH DAY YEAR Aug 18 19 81		7d. HOUR 10 P M			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Poland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH None					
10. CITY OR TOWN OF DEATH D.C. Spg		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hosp.				12a. USUAL OCCUPATION (TYPE OF WORK) Eastern Europe Visa Service		12b. KIND OF BUSINESS OR INDUSTRY Travel Agency			
13a. STATE Md		13b. COUNTY Mont.		13c. CITY OR TOWN D.C. Spg		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 1524 Aylesbury St			
14. FATHER'S NAME FIRST MIDDLE LAST UNK Karpinski				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Janja Grodecka							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, UNKNOWN) (IF YES, GIVE WAR OR DATES) None				16b. SOCIAL SECURITY NO. 062 32 9820		17. INFORMANT ADDRESS Same as above Elfriede Karpinski (Wife)					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 4391 IMMEDIATE CAUSE (a) <u>Acute Myocardial Dill</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) <u>Chronic Myocardial Dill</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>None</u>											
19a. DATE OF OPERATION <u>None</u>				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE John Rogers				TITLE (SPECIFY) M.D. Dep.		MEDICAL EXAMINER 1919 Seminary Rd. S.S.Md.		DATE SIGNED Aug. 18/1981			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 8/21/81		23c. NAME OF CEMETERY OR CREMATORY Lee's Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Wash. D.C.					
24. FUNERAL DIRECTOR NAME ADDRESS Hines/Rinaldi F.H. 11800 N.H. Ave. S.S.Md.											
25a. RECEIVED BY REGISTRAR AUG 21 1981											
25b. REGISTRAR'S SIGNATURE											



COLLECTED

RECEIVED BY THE NATIONAL ARCHIVES

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

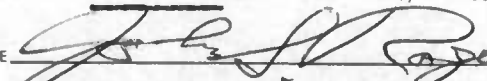
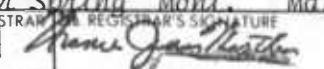
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

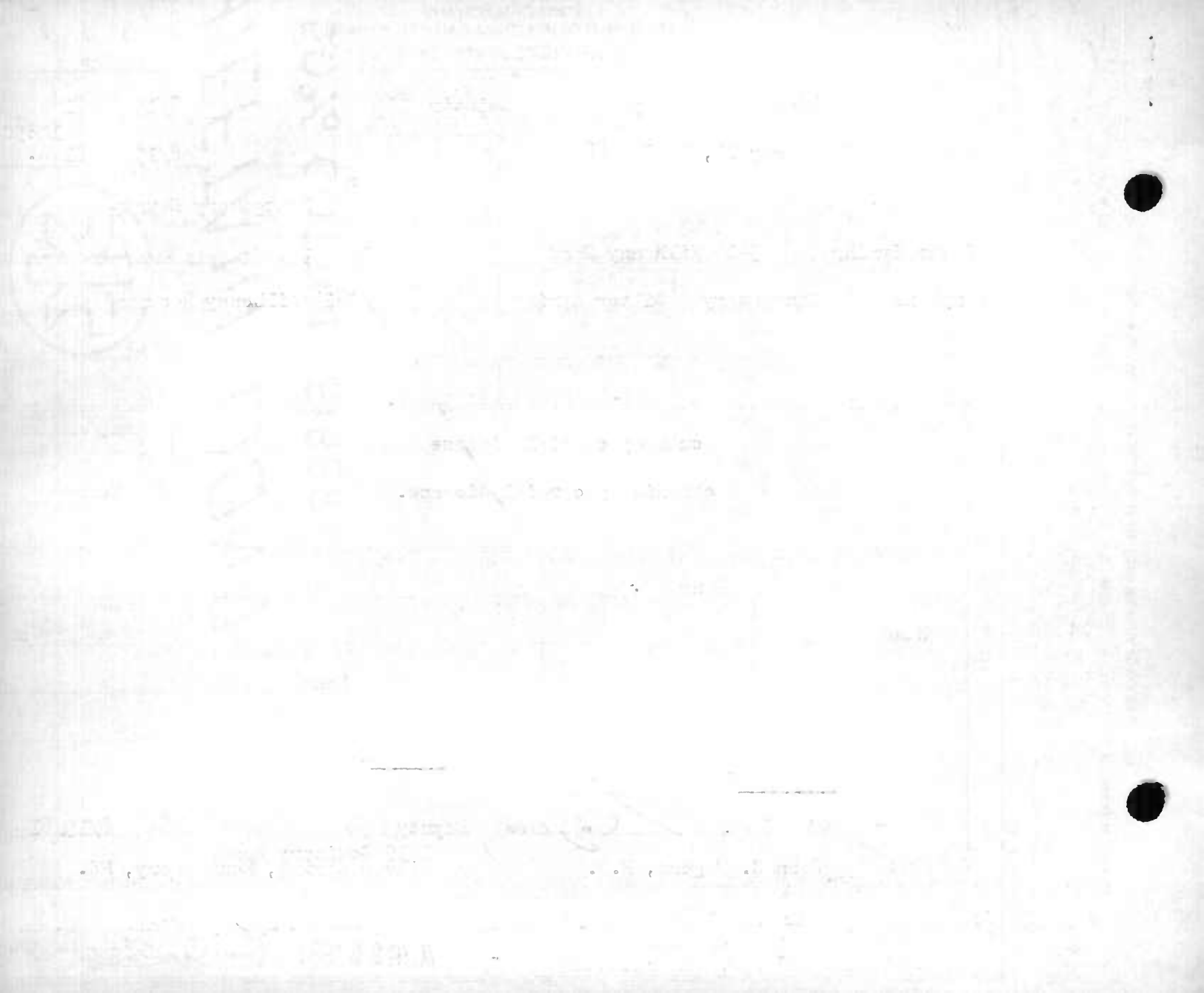
Item 7a 8558 8/18/81										
MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print) First Middle Last Katie Kay					2a. DATE OF DEATH Month Day Year 8 4 81					2b. HOUR 5:10A.M.
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH December 23, 1894			6. AGE (In years last birthday) 86 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) N.Y.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.				
10. CITY OR TOWN OF DEATH Bethesda			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Westwood Rd. 5101 Ridgefield Rd.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife			12b. KIND OF BUSINESS OR INDUSTRY Home	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE md			13b. COUNTY mont		13c. CITY OR TOWN Bethesda		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 5101 Ridgefield Road	
14. FATHER'S NAME First Middle Last MAX CHAIKIN			15. MOTHER'S MAIDEN NAME First Middle Last VENNIE KAMINKOWITZ							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) NO None			16b. SOCIAL SECURITY NO.		17. INFORMANT HARRY KAY (Son)			Address 7109 Arran Pt. Bethesda, Maryland		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) LEFT VENTRICULAR FAILURE DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 4140 (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 20 min. 15 yrs.										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) DIABETES MELLITUS										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (his hospital) attended the deceased from 7-31 1981 to 8-4 1981 , that (I) (we) last saw the deceased alive on 7-31 1981 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Stanley W. Kirstein M.D.					22c. PHYSICIAN'S NAME (Type) STANLEY W. KIRSTEIN, M.D.		22d. ADDRESS 5410 Conant Ave N.W. D.C. 20015		22e. DATE SIGNED 8-4-81	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
BURIAL		AUG. 5, 1981		OHEV SHOLOM TAL MUD TORAH		Washington D.C.				
24. FUNERAL DIRECTOR DANZANSKY GOLDBERG CHAPELS 1170 ROCKVILLE, MD. 20851										

VRA15 (4)
25m-1/70

Feb 5 1981

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGES 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

FOR 1- STATE REGISTRAR										STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										21689 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Alice Mary Keister										2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 8/19 19 81										2b. HOUR 10:50 A. M.	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR May 16, 1894		6. AGE (IN YEARS) LAST BIRTHDAY YRS. 87		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.		2c. DATE PRONOUNCED DEAD 8/19 19 81		2d. HOUR A. M.							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D. C.				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD									
10. CITY OR TOWN OF DEATH Silver Spring				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3424 Kilkenny Road				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Film Inspectress Universal Film				12b. KIND OF BUSINESS OR INDUSTRY									
13a. STATE Maryland				13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 3424 Kilkenny Street											
14. FATHER'S NAME FIRST MIDDLE LAST William Keister						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Whelan															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No				16b. SOCIAL SECURITY NO. 577-10-1941		17. INFORMANT Nephew Robert D. Caruana				ADDRESS same as 13											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial disease</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>chronic myocardial disease.</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. 4291														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Years							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). None																					
19a. DATE OF OPERATION None				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) None													
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE													
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																					
ACTUAL SIGNATURE  EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers, M.D.										TITLE (SPECIFY) Deputy MEDICAL EXAMINER				DATE SIGNED 8/19/81							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE Aug. 21, 1981		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven				23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring Mont. Md.											
24. FUNERAL DIRECTOR NAME Francis J. Collins ADDRESS 500 University Blvd., W. Silver Spring, Md.										25a. DATE REC'D. BY REGISTRAR AUG 25 1981						REGISTRAR'S SIGNATURE 					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

NO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO. 8 1 2 1 6 9 0									
1. DECEASED NAME (TYPE OR PRINT) Adele L. Kellar					2a. DATE OF DEATH MONTH DAY YEAR August 16, 1981					2b. HOUR 6:25 P.M.				
3. SEX female		4. RACE caucasian		5. DATE OF BIRTH MONTH DAY YEAR March 4, 1905		6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Minnesota		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery Co. MD.								
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Court Stenographer		12b. KIND OF BUSINESS OR INDUSTRY								
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 3292 Gleneagles Drive						
14. FATHER'S NAME FIRST MIDDLE LAST unknown		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST unknown												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 535-28-4790		17. INFORMANT friend		ADDRESS same as 13								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardio Respiratory Arrest 4413 DUE TO, OR AS A CONSEQUENCE OF (b) Renal Failure DUE TO, OR AS A CONSEQUENCE OF (c) Rupture Abdominal Aortic Aneurysm										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1-2 min 10 days 10 days				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Severe peripheral vascular Disease														
19a. DATE OF OPERATION 8/6/81		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Ruptured Abdominal Aneurysm		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY: HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE										
22a. I certify that (I) (this hospital) attended the deceased from Aug 6th 19 81 to Aug 16 19 81 , that (I) (we) last saw the deceased alive on Aug 16 19 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE James F. Marquez		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8/16/81								
22d. PHYSICIAN'S NAME (TYPE OR PRINT) James F. Marquez		22e. ADDRESS 1811 Prince Philip Dr. Olney Md 20832												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE Aug. 17, 1981		23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria Virginia								
24. FUNERAL DIRECTOR NAME Francis J. Collins		ADDRESS 500 University Blvd., W. Silver Spring, Md.		25a. DATE REC'D. BY REGISTRAR AUG 18 1981		25b. REGISTRAR'S SIGNATURE James J. Martin								

NO 103 8003



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8121691	
1 - STATE REGISTRAR										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) Killian Edward Kendrick						2a. DATE OF DEATH MONTH DAY YEAR AUGUST 6, 1981		2b. HOUR 2:30 P M			
3. SEX Male		4. RACE Cauc		5. DATE OF BIRTH MONTH DAY YEAR SEPT 13, 1903		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VIRGINIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.					
10. CITY OR TOWN OF DEATH SILVER SPRING		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOLY CROSS HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) PLUMBING INSP.		12b. KIND OF BUSINESS OR INDUSTRY D.C. GOVT.			
13a. STATE MARYLAND			13b. COUNTY MONTGOMERY		13c. CITY OR TOWN SILVER SPRING		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 2420 EVANS DRIVE		
14. FATHER'S NAME FIRST MIDDLE LAST CHARLES E. KENDRICK				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MATILDA KILLIAN							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. WW II 577-07-7743		17. INFORMANT ADDRESS MARGARET E. KENDRICK SAME AS 13 WIFE							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive subarachnoid hemorrhage 4310 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Severe arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) 5 yrs											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: None											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 8/6/81 , 19 81 , to 8/6 , 19 81 , that (I) (we) lost saw the deceased alive on 8/6/81 , 19 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (d-d) (do not) view the body after death.											
27a. SIGNATURE Francis J. Collins DEGREE						27b. DATE SIGNED 8/6/81					
27c. PHYSICIAN'S NAME (TYPE OR PRINT) R. Collins MD						27d. ADDRESS 10620 Gg Ave SS MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 8/10/81		23c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN		23d. LOCATION CITY OR TOWN COUNTY STATE SILVER SPRING MONT MD.					
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS ADDRESS 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901						25a. DATE REC'D. BY REGISTRAR AUG 7 1981 25b. REGISTRAR'S SIGNATURE Thane Jan Nith					

1991

1992

X

1993

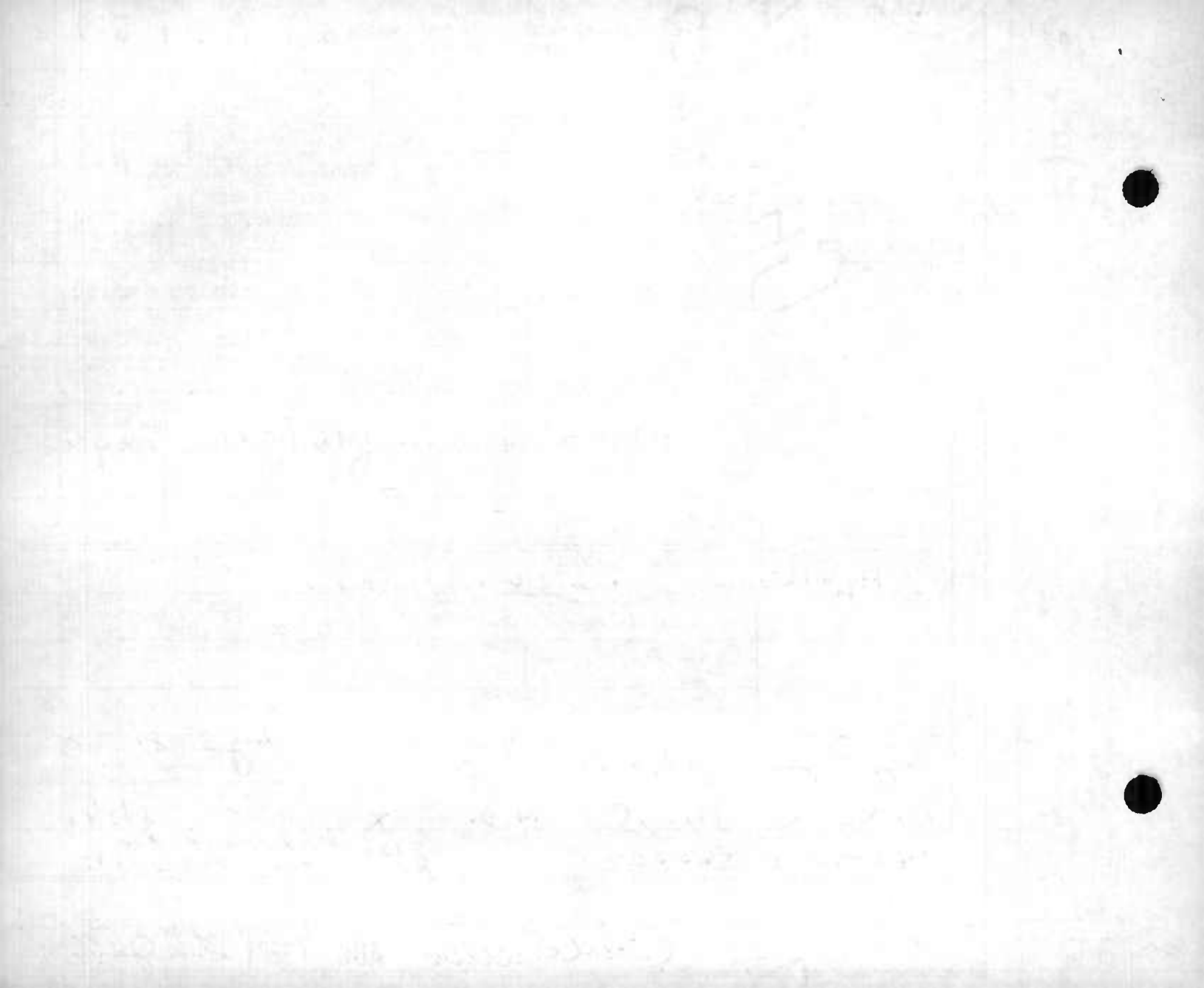
1994

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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#5, F51mg559 9/10/81 kam										STATE OF MARYLAND									
1- FOR STATE REGISTRAR										DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
1 DECEASED NAME (TYPE OR PRINT)										2a DATE OF DEATH MONTH DAY YEAR									
Frank E. Kenney										Aug. 3, 1981									
3 SEX Male										4 RACE white									
5 DATE OF BIRTH MONTH DAY YEAR										6 AGE (IN YEARS LAST BIRTHDAY)									
Apr. 20, 1901										80									
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)										7b CITIZEN OF WHAT COUNTRY?									
Washington, DC										USA									
8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>										9 BALTIMORE CITY OR COUNTY OF DEATH									
10 CITY OR TOWN OF DEATH										11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)									
Silver Spring										500 Beaumont Road,									
12a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										12b USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)									
13a STATE										13b CITY OR TOWN									
Maryland										Kensington									
14 FATHER'S NAME FIRST MIDDLE LAST										15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST									
John Francis Kenney										Mary Ellen Costello									
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)										16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)									
yes										WW1 577-18-3189									
17 INFORMANT (daughter)										ADDRESS 500 Beaumont Rd., Augusta K. Whitacre-Sil. Spr. Md.									
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Melastotic carcinoma of the bladder</u> 1889										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>one year</u>									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										DUE TO, OR AS A CONSEQUENCE OF (b) _____									
DUE TO, OR AS A CONSEQUENCE OF (c) _____										PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Hypokalemia; chronic brain syndrome</u>									
19a DATE OF OPERATION										19b CONDITION FOR WHICH OPERATION WAS PERFORMED									
20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19									
21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)										21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK									
21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)										21f LOCATION STREET CITY OR TOWN COUNTY STATE									
22a I certify that (1) this hospital attended the deceased from <u>July 30, 1981</u> to <u>Aug 3, 1981</u> , that (2) (we) lost saw the deceased alive on <u>July 30, 1981</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (did not) view the body after death.										22b SIGNATURE <u>Martin C. Sharbel</u> DEGREE <u>M.D.</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>									
22c DATE SIGNED <u>8/3/81</u>										22d ADDRESS <u>3720 FARRAGUT Ave KENSINGTON, MD 20895</u>									
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>										23b DATE <u>8-5-1981</u>									
23c NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven</u>										23d LOCATION CITY OR TOWN COUNTY STATE <u>Sil. Spr. Montgomery Md.</u>									
24 FUNERAL DIRECTOR <u>Warner E. Pumphrey, Inc.</u>										25a DATE REC'D. BY REGISTRAR <u>AUG 7 1981</u>									
8434 Ga. Ave., S.S. Md.										<u>Blanche W. Wynn</u>									



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M / 181
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 2 1 6 9 3

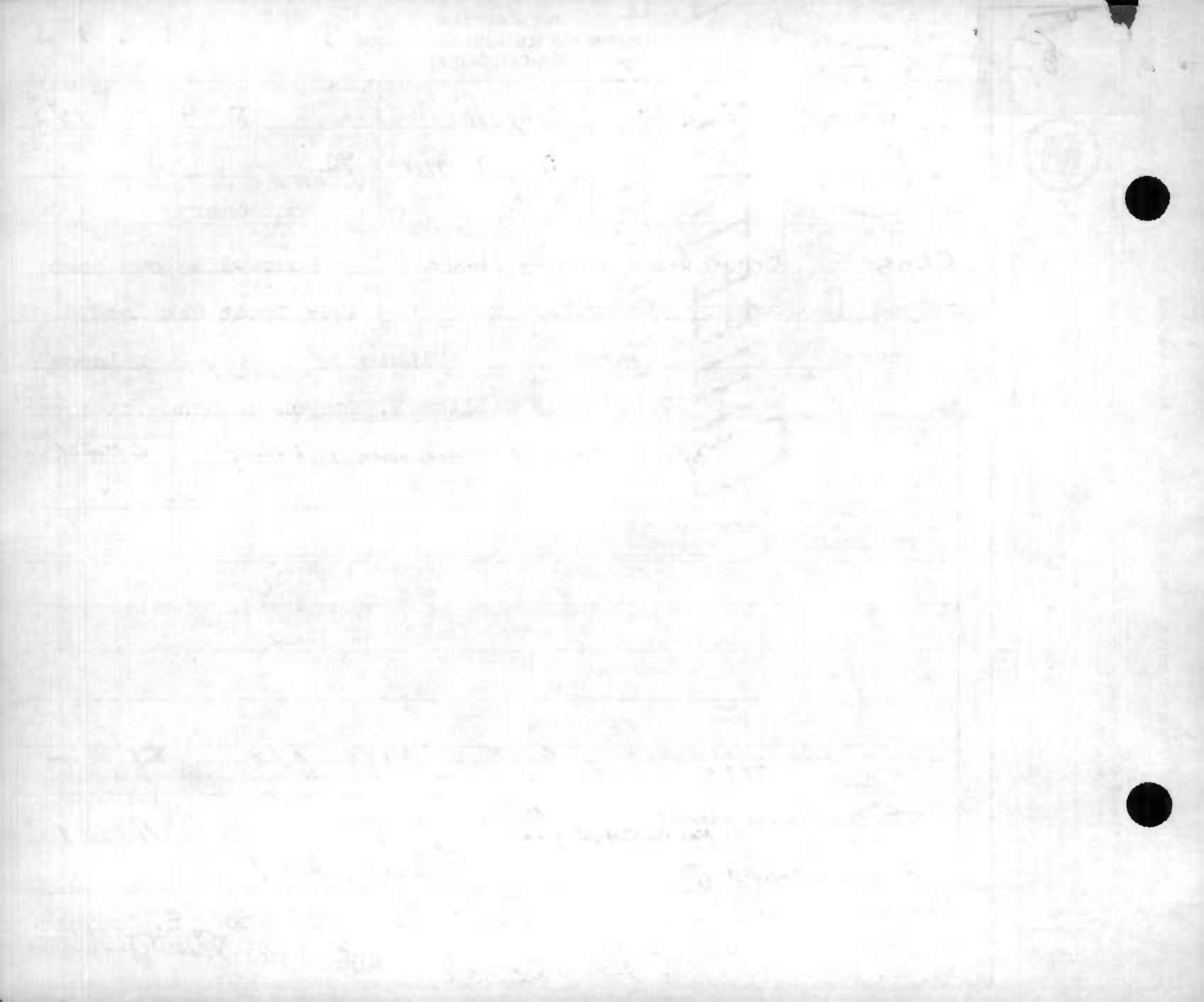
REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		MONTH DAY YEAR		10 ⁴⁵ AM	
FIRST MIDDLE LAST		8 4 81			
Janet Lucille Kenyon					
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR	
F	white	MONTH DAY YEAR	72	IF UNDER 24 HRS	
		2 9 1909		MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
Washington, DC	USA		Montgomery MD		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY		
OLney	Brooke Grove Nursing Home	Housewife	own home		
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS	
Maryland	Montgomery	Rockville	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	4509 Great Oak Road,	
14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME	13e. ADDRESS			
FIRST MIDDLE LAST	FIRST MIDDLE LAST	13e. ADDRESS			
Henry Payne	Minnie Blincoe				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO.	17. INFORMANT	13e. ADDRESS		
no	579-48-6625	William E. Kenyon-husband-	same as		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART I. DEATH WAS CAUSED BY					
IMMEDIATE CAUSE (a) Squamous Cell Carcinoma of Lung					
DUE TO, OR AS A CONSEQUENCE OF					
(b)					
DUE TO, OR AS A CONSEQUENCE OF					
(c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
		P.M. 19			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (the hospital) attended the deceased from 6/18, 19 81, to 8/4, 19 81, that (I) (we) lost saw the deceased alive on 2/20, 19 81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did not) view the body after death.					
22b. SIGNATURE				22c. DATE SIGNED	
A.D. Bonifant				8/4/81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS	
A.D. BONIFANT				OLney, Md	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		8-6-1981		Ft. Lincoln Cemetery	
				23d. LOCATION CITY OR TOWN COUNTY STATE	
				Brentwood Pr. Georges Md	
24. FUNERAL DIRECTOR OR NAME ADDRESS				25a. DATE REC'D BY REGISTRAR	
Warner E. Pumphrey, Inc., 8434 Ga. Ave., S.S. Md.				AUG 7 1981	

MEDICAL CERTIFICATION

3202
BP

Lee



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office of the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 1 2 1 6 9 4			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH			
FIRST MIDDLE LAST ISADORE KESSLER				MONTH DAY YEAR 8-12-81			
3. SEX				2b. HOUR			
Male				2:24P			
4. RACE				6. AGE (IN YEARS LAST BIRTHDAY)			
White				59 YRS.			
5. DATE OF BIRTH				IF UNDER 1 YEAR			
MONTH DAY YEAR Nov 30, 1921				MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?			
Maryland				USA			
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			
Silver Spring				Holy Cross Hospital			
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY			
C. P. A.				Auditing			
13a. STATE				13b. COUNTY			
Maryland				Montgomery			
13c. CITY OR TOWN				13d. INSIDE CITY LIMITS?			
Sil. Spg.				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME			
FIRST MIDDLE LAST Morris Kessler				FIRST MIDDLE LAST Gussie Page			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.			
Yes				WW II 579-07-0691			
17. INFORMANT				ADDRESS			
Linda Mae Kessler				2811 Dennis Avenue, SSpg, Md			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). Part I. DEATH WAS CAUSED BY:				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
IMMEDIATE CAUSE (a) Metastatic Colonic Carcinoma				3 Mos			
1539							
DUE TO, OR AS A CONSEQUENCE OF							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
DUE TO, OR AS A CONSEQUENCE OF							
DUE TO, OR AS A CONSEQUENCE OF							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
N/A							
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			
20a. AUTOPSY?				20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY			
				HOUR A.M. MONTH DAY YEAR P.M. 19			
21d. INJURY OCCURRED				21e. PLACE OF INJURY			
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			
21f. LOCATION				CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 8/17 , 19 81 , to 8/12 , 19 81 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If I did not view the body after death, so state.)							
22b. SIGNATURE				22c. ADDRESS			
Alan I. Kermaier, MD				9801 GEORGIA AVE. SS MD 20902			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			
ALAN I. KERMAIER, MD				9801 GEORGIA AVE. SS MD 20902			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE			
Burial				Aug 14, 1981			
23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION			
King David Mem. Garden				Falls Church, Virginia			
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR			
NAME ADDRESS Danzansky-Goldberg Chapels; 1170 Rockville Pike				AUG 17 1981			
25b. REGISTRAR'S SIGNATURE							
James J. Hester							

NOT RECORDED

9462-16-1-13

1/23/13

1/23/13

RECEIVED

RECEIVED

RECEIVED

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1/23/13

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health officer with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 977-7035.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. FOR STATE REGISTRAR				4101 CONGER ST. OFC. 2-12834-95			
I. DECEASED NAME (TYPE OR PRINT) Chong Bo Kim				2a. DATE OF DEATH 8/2/81		2b. HOUR 10:30 P.M.	
3. SEX female		4. RACE Korean		5. DATE OF BIRTH MONTH Dec. DAY 10, YEAR 1892		6. AGE (IN YEARS LAST BIRTHDAY) 88	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Korea		7b. CITIZEN OF WHAT COUNTRY? Korea		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sullivan		12a. USUAL OCCUPATION (TYPE OR WORK FOR MOST OF WORKING LIFE) housewife		12b. KIND OF BUSINESS OR INDUSTRY home	
13a. STATE Maryland				13b. CITY OR TOWN Montgomery		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST Unknown MIDDLE Unknown LAST Unknown				15. MOTHER'S MAIDEN NAME FIRST Unknown MIDDLE Unknown LAST Unknown			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. none		17. INFORMANT ADDRESS Ki Young Kim same as 13c			
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4360 cerebrovascular accident DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 month
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the hospital) attended the deceased from 7/12/81 to 8/3 19 81 , that (I) (we) last saw the deceased alive on 8/3 19 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.							
22b. SIGNATURE Marvin Wadler				DEGREE M.D.		22c. DATE SIGNED 8/4/81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MARVIN WADLER				22e. ADDRESS 8218 Wisconsin Av. BETH, MD.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/5/81		23c. NAME OF CEMETERY OR CREMATORY Norbeck Memorial Park		23d. LOCATION Norbeck Montgomery, Md.	
24. FUNERAL DIRECTOR NAME Tyson Wheeler Funeral Home, Inc. ADDRESS 1331 Rockville Pike Rockville, Maryland				25a. DATE REC'D. BY REGISTRAR AUG 10 1981		25b. REGISTRAR'S SIGNATURE James J. Miller	

10/20/44

atm

so

Strong

66

Dec. 10, 1944

Korean

Female

x

Korea

Korea

None

Montgomery

1101 Center Street

x

Montgomery Wheaton

Unknown

Unknown

Mr Young has been in the

none

--

no

Montgomery Park Memorial Park, Montgomery, Md.

10/20/44

Female

Tracy Wheeler Funeral Home, Inc.

1555 Rockville Pike Rockville, Maryland

Dr. Ball released body

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 7 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 22 is marked, the medical examiner must be notified of cause.

CLEARED BY MEDICAL EXAMINER

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR			8 1 2 1 6 9 6 REG. NO.						
1. DECEASED NAME (TYPE OR PRINT) Bernice J. King			2a. DATE OF DEATH MONTH DAY YEAR August 12, 1981			2b. HOUR 8:32 PM			
3. SEX female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Nov. 27, 1907		6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, DC		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.			
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Home	
13a. STATE Maryland			13b. COUNTY Montgomery		13c. CITY OR TOWN Bethesda		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Samuel A. Jones			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ada Yost						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 220 34 8799		17. INFORMANT ADDRESS 193 Ireland Street David J. King Rockville, Maryland				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>intractable ventricular fibrillation</u> 4149 DUE TO, OR AS A CONSEQUENCE OF (b) <u>coronary heart disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>SEPT 8-12</u> , 19 <u>80</u> , to <u>8-12</u> , 19 <u>81</u> , that (I) (we) lost <u>saw</u> the deceased alive on <u>8-12</u> , 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Thomas G. Sinderson, MD			DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 8-13-81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) THOMAS G. SINDERSON, MD			22e. ADDRESS 11125 ROCKVILLE PIKE, ROCKVILLE, MD.						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE August 17, 1981		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION CITY OR TOWN COUNTY STATE Arlington, Virginia		
24. FUNERAL DIRECTOR NAME ROBERT A. PUMPHREY FUNERAL HOMES, P.A., BETHESDA, MARYLAND					25a. DATE REC'D. BY REGISTRAR 25b. <u>AUG 18 1981</u>				

1. The purpose of this study is to determine the effect of the proposed changes on the overall system. The study will be conducted in three phases: (a) a preliminary study to determine the scope of the problem, (b) a detailed study of the proposed changes, and (c) a final study to determine the effect of the changes on the overall system.

2. The proposed changes are being made to the existing system in order to improve its efficiency and to reduce the cost of operation. The changes are being made in the following areas: (a) the organization of the system, (b) the methods of operation, and (c) the equipment used.

3. The results of the study will be used to determine the effect of the proposed changes on the overall system. The study will be conducted in three phases: (a) a preliminary study to determine the scope of the problem, (b) a detailed study of the proposed changes, and (c) a final study to determine the effect of the changes on the overall system.

4. The proposed changes are being made to the existing system in order to improve its efficiency and to reduce the cost of operation. The changes are being made in the following areas: (a) the organization of the system, (b) the methods of operation, and (c) the equipment used.

5. The results of the study will be used to determine the effect of the proposed changes on the overall system. The study will be conducted in three phases: (a) a preliminary study to determine the scope of the problem, (b) a detailed study of the proposed changes, and (c) a final study to determine the effect of the changes on the overall system.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH - 17
(VR A15 ME (5))
15M 2/80

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR
1- STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST Stanley		MIDDLE J.		LAST Kirchenbauer		2a. DATE KNOWN OF DEATH		<input checked="" type="checkbox"/> MONTH		DAY		YEAR		2b. HOUR	
								8		27		81		5:11		AM	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS) LAST BIRTHDAY		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD		MONTH DAY YEAR		2d. HOUR	
M		W		April 18, 1938		43 YRS.						Aug 22, 1981		19		24 AM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH											
Baltimore, Md.		USA		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Montgomery											
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY											
Olney		Montgomery Gen. Hospital		Medical Physician													
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS									
Md		Montgo		Rockville		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		15224 Meadow Lake									
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST															
Stanley		Kirchenbauer		Anna		unk											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Same as above											
Yes		219 26 4834		DeAnne Kirchenbauer (Wife)													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
4291		Acute Myocardial Dis.															
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.		(b)		DUE TO, OR AS A CONSEQUENCE OF													
				(c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a.		None															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?		YES <input type="checkbox"/> NO <input type="checkbox"/>											
None																	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE													
22a. I certify that I took charge of the remains described above, held on death resulted from:		Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion													
ACTUAL SIGNATURE		TITLE (SPECIFY)		MEDICAL EXAMINER		DATE SIGNED											
John Rogers		M.D. Dege		1919 Seminary Rd. S.S. Md.		Aug 27, 1981											
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE											
Burial		8/29/81		Parklawn Cemetery		Rockville Mont. Md.											
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE													
Hines/Rinaldi F.H. 11800 N.H. Ave. S.S. Md.		SEP 01 1981		Charles J. Kirchenbauer													

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Monopony

Monopony G. A. H. (H. A. H.)

SEP 6 1981

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 81 21698	
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
		IDA KITT				AUG 17 1981				5:55 PM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
FEMALE		CAUCASIAN		FEB 12 1902		79 YRS.		MONTHS DAYS		HOURS MIN.	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
RUSSIA		U.S.				MONTGOMERY MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION									
SILVER SPRING		HOLY CROSS - SILVER SPRING MD.									
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY									
HOUSEWIFE		AT HOME									
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
MARYLAND				BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		Apt. 602 3601 FORDS LANE #21215			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME							
ISRAEL DAVID ENGLE				BESSIE							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT					
NO				219-22-6053		MRS. FRANCES F. DEITZ 2012 CASCADE RD., SILVER SPRING, MD 20902					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).											
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) <i>Acute Myocardial Infarction</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>HOURS</i>											
4100 DUE TO, OR AS A CONSEQUENCE OF (b) <i>Coronary artery Disease</i> <i>YRS.</i>											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <i>Generalized arteriosclerosis</i> <i>YRS.</i>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <i>Chronic renal failure</i>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				19c. AUTOPSY?		19d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. TIME OF INJURY				20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART II)			
				HOUR A.M. MONTH DAY YEAR P.M. 19							
21a. INJURY OCCURRED				21b. PLACE OF INJURY				21c. LOCATION			
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				[AT HOME STREET FACTORY, OFFICE, FARM, ETC.]				STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>May 15, 1981</i> to <i>Aug. 17, 1981</i> , that (I) (we) lost saw the deceased alive on <i>Aug. 17, 1981</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE								DEGREE		22c. DATE SIGNED	
<i>Robert L. Goldman MD</i>								ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		<i>8/17/81</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)								22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION			
BURIAL				8-20-81		BNAI ISRAEL CONG.		BALTIMORE COUNTY STATE MD			
24. FUNERAL DIRECTOR SOL LEVINSON & BROS., INC.								25a. DATE REC'D. BY REGISTRAR			
NAME ADDRESS 6010 REISTERSTOWN RD., BALTO., MD 21215								25b. REGISTRAR'S SIGNATURE <i>James J. [Signature]</i>			

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FOR
1. STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 2 1 6 9 9

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) WALTER F. KOCH			2a. DATE OF DEATH MONTH DAY YEAR 8-11-81			2b. HOUR 120 M			
3. SEX M		4. RACE CAUC.		5. DATE OF BIRTH MONTH DAY YEAR 6 4 09		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASHINGTON, D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.			
10. CITY OR TOWN OF DEATH SILVER SPRING		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOLY CROSS HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) PIPE FITTER WASH. TERMINAL CO.		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MARYLAND		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN SILVER SPRING		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST MICHAEL V. KOCH		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY V. ROBERTS				13e. STREET ADDRESS 202 HANNES STREET			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 718-14-9483		17. INFORMANT LILLIAN M. KOCH		ADDRESS SAME AS 13		WIFE	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiogenic Shock 4100 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Due to, or as a consequence of, Probable Ventricular Fibrillation (c) Due to, or as a consequence of, acute myocardial infarction								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hour 6 hours 6 hours	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NO: WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 8-10 19 81 , to 8-11 19 81 , that (I) (we) last saw the deceased alive on 8-11 19 81 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.									
22b. SIGNATURE John A. Galotto MD		22c. PHYSICIAN'S NAME (TYPE OR PRINT) John A. Galotto MD				22d. ADDRESS 5225 Backlick Rd Baltimore, Md 21014		22e. DATE SIGNED 8/11/81	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 8/13/81		23c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN		23d. LOCATION CITY OR TOWN COUNTY STATE SILVER SPRING MONT MD.			
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS ADDRESS 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901						25a. DATE REC'D. BY REGISTRAR AUG 12 1981		25b. REGISTRAR'S SIGNATURE James J. [Signature]	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: This certificate requires that the death certificate be completed within 24 hours after death. Pages may be retained by the hospital or attended to physician.

TO FUNERAL DIRECTOR: This certificate should be completed by the attending physician and completed, filled in by the funeral director, page 3 should be attached to the certificate as the initial filing. The funeral director should remove carbon papers. Pages 1 and 2 should be filed with the State Department of Health and Mental Hygiene for filing, registration, and removal.

IMPORTANT: If item 21 (length of time in hospital) is not filled in, the medical examiner must be notified.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 1 2 1 7 0 0	
1. FOR STATE REGISTRAR				REG. NO.	
1 DECEASED NAME (TYPE OR PRINT) MILTON			2a. DATE OF DEATH MONTH DAY YEAR 8 23 81		
3 SEX Male			4 RACE White		2b. HOUR 12 05 AM
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New Jersey		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		6. AGE (IN YEARS LAST BIRTHDAY) 72	
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Merchant		12b. KIND OF BUSINESS OR INDUSTRY Liquor		13a. STREET ADDRESS 5225 Pooks Hill Road, #1104-NO.	
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Bethesda	
14. FATHER'S NAME FIRST MIDDLE LAST Herschel Kolodin		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Hanna Rothstein		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	
16b. SOCIAL SECURITY NO. 578-48-3965		17. INFORMANT William Kolodin		17b. ADDRESS 2709 Shanandale Drive Silver Spring, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 4100 Acute Myocardial Infarction. Coronary artery disease.					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 1980 Aug 23 81	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that (I) (this hospital) attended the deceased from Aug 23 1981 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.		22b. SIGNATURE Robert H. ... DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
22c. DATE SIGNED 8/23/81		22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS 8630 PENTON 2 81 S.C. 81000	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/24/1981		23c. NAME OF CEMETERY OR CREMATORY Beth Jacob Congregation	
23d. LOCATION CITY OR TOWN COUNTY STATE Finksburg, Maryland		24. FUNERAL DIRECTOR Donald M. Stein Hebrew Memorial F.H.		25a. DATE REC'D. BY REGISTRAR AUG 26 1981	
25b. REGISTRAR'S SIGNATURE ...		25c. REGISTRAR'S NAME ...		25d. REGISTRAR'S ADDRESS ...	

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Handwritten text, possibly "LUN" or "LUNY", appearing below the circular stamp.



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 21701	
1. DECEASED NAME (TYPE OR PRINT) Josephine M. Komarek							2a. DATE KNOWN OF DEATH ESTIMATED Aug 9 1981		2b. HOUR 8:30 AM		
3. SEX Female	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR Dec. 24, 1915		6. AGE (IN YEARS) (LAST BIRTHDAY) 65 YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD Aug 9 1981		2d. HOUR 8:03 AM		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.				
10. CITY OR TOWN OF DEATH Olney		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Waitress		12b. KIND OF BUSINESS OR INDUSTRY Restaurant			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE Maryland		13b. COUNTY Prince George		13c. CITY OR TOWN Temple Hills		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 3906 - 23rd Parkway			
14. FATHER'S NAME FIRST MIDDLE LAST Dominic Mammana				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Maria F. Sacchetti							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 194-16-7210		17. INFORMANT Marietta P. Merrill ADDRESS 3723 Capulet Terr. Silver Spring, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 1629 IMMEDIATE CAUSE (a) Massive Hemiplegia Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) Undifferentiated Carcinoma (c) Soft Lung with metastases										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE Richard L. Wheelton				TITLE (SPECIFY) Deputy Medical Examiner				DATE SIGNED Aug 9 1981			
EXAMINER'S NAME (TYPE OR PRINT) RICHARD L. WHEELTON				ADDRESS 7100 Bell Ave College Park, Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l. Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Arlington Virginia			
24. FUNERAL DIRECTOR NAME ADDRESS George P. Kalas Funeral Home Oxon Hill, Md.				25a. DATE REC'D. BY REGISTRAR AUG 12 1981		25b. REGISTRAR'S SIGNATURE James J. Martin					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 1 2 1 7 0 2			
1. FOR STATE REGISTRAR				CERTIFICATE OF DEATH			
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH			
YOUNG BIN KONG				8 3 81 9 30 P			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS (LAST BIRTHDAY))	
MALE		ORIENTAL		SEPT 15, 1905		75 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
KOREA		KOREA				Montgomery MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Bethesda		Suburban Hospital		NONE			
13a. STATE				13b. COUNTY		13c. CITY OR TOWN	
MARYLAND				MONTGOMERY		SILVER SPRING	
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME			
SA JUN KONG				UNKNOWN			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)				16b. SOCIAL SECURITY NO.		17. INFORMANT	
NO						SON	
				SHIGAK KONG, 3115 HEWITT AVE., SILVER SPRING,			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)							
PART I. DEATH WAS CAUSED BY:							
IMMEDIATE CAUSE (a) <u>Coma</u>							
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Metastatic Carcinoma</u>							
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Jaundice</u>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u></u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
		HOUR A.M. MONTH DAY YEAR					
		P.M. 19					
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION			
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>July 6, 19 81</u> to <u>August 3, 19 81</u> that (I) (we) lost saw the deceased alive on <u>August 3, 19 81</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE		DEGREE				22c. DATE SIGNED	
<u>Boo K. Kim</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				8/4/81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS				MD 20760	
Boo K. Kim		16220 Frederic Rd, Gaith					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION	
BURIAL		8/6/81		NORBECK MEMORIAL PARK		CITY OR TOWN COUNTY STATE	
						NORBECK MONT MD.	
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
NAME FRANCIS J. COLLINS				AUG 7 1981		<u>Francis J. Collins</u>	
500 UNIV. BLVD., W., SILVER SPRING, MD. 20901							

SEP 18 2 8

YOUNG - 1311

Montgomery

Estimated 1 September 1941

1941

James
The above

X

James H. Young

James H. Young

James H. Young

James H. Young

James H. Young

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 2 1 7 0 3

REG. NO.

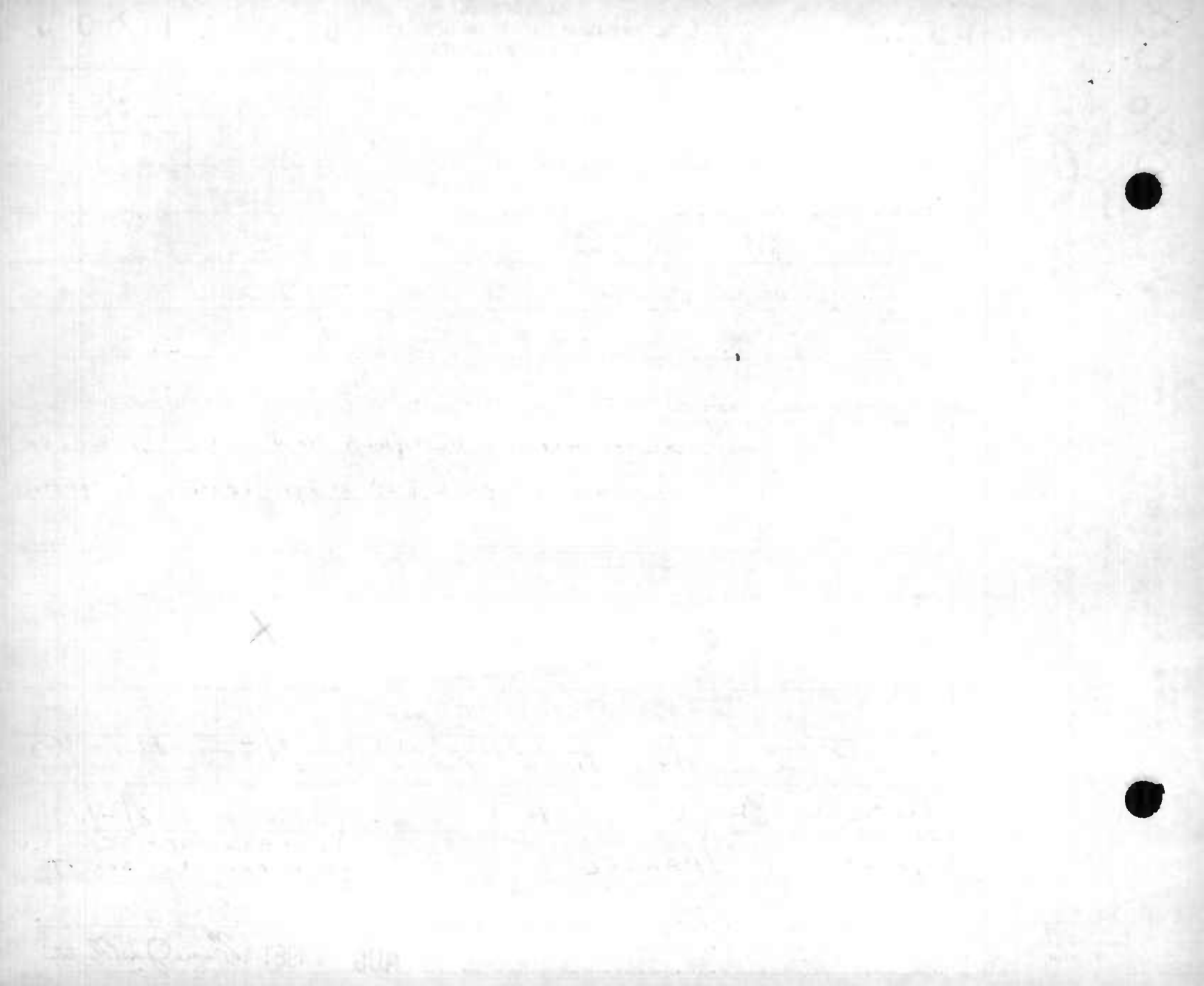
1 - FOR
STATE
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR
ROSINA F. LABOFISH					AUGUST 4, 1981				4:30 P.M.
3 SEX	4 RACE	5 DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR		IF UNDER 24 HRS.		
FEMALE	CAUCASIAN	JULY 24, 1891		90 YRS	MONTHS		DAYS		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b CITIZEN OF WHAT COUNTRY?	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH				MD.	
MARYLAND	U.S.A.			MONTGOMERY					
10 CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN STATE FACILITY, GIVE STREET ADDRESS)		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY				
WHEATON	11113 DODSON LANE		HOUSEWIFE						
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE 13b CITY OR TOWN 13c INSIDE CITY LIMITS?					13d STREET ADDRESS				
MARYLAND MONTGOMERY WHEATON YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					11113 DODSON LANE				
14 FATHER'S NAME FIRST MIDDLE LAST					15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST				
FRANK F. FINOTTI					PAULINA EDELEN				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17 INFORMANT ADDRESS					
NO		578-46-5684B		LOUIS W. LABOFISH SAME AS 13 HUSBAND					
18 CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) SEPTICEMIA + DEHYDRATION 0389 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) CHRONIC ORGANIC BRAIN SYNDROME DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 WEEKS 5 YEARS									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY?		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR (A.M. MONTH DAY YEAR P.M.		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (I) (this hospital) attended the deceased from 8/4 1981 to 8/4 1981, and that in my (my) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE Martin C. Sharbel					DEGREE M.D.			22c DATE SIGNED 8/4/81	
22d PHYSICIAN'S NAME (TYPE OR PRINT) MARTIN C. SHARBEL					22e ADDRESS 3720 FARRAGUT AVE KENSINGTON MD-20895				
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION CITY OR TOWN COUNTY STATE			
BURIAL		8/7/81		GATE OF HEAVEN		SILVER SPRING MONT MD.			
24 FUNERAL DIRECTOR NAME FRANCIS J. COLLINS 500 UNIVERSITY BLVD., W., SILVER SPRING, MD.					25a DATE REC'D. BY REGISTRAR AUG 7 1981		25b REGISTRAR'S SIGNATURE Francis J. Collins		

MEDICAL CERTIFICATION

150

29



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and give approval.

FOR
1. STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 2 1 / 0 4

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Lucy K LAFOURCADE			2a. DATE OF DEATH MONTH DAY YEAR 8-21-81			2b. HOUR 12:15 PM				
3. SEX FEMALE		4. RACE White.		5. DATE OF BIRTH MONTH DAY YEAR Jan. 4, 1907		6. AGE (IN YEARS LAST BIRTHDAY) 74		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington		7b. CITIZEN OF WHAT COUNTRY? D. C. U. S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.				
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION Holy Cross Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) House Wife.		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Maryland.			13b. COUNTY Montg.		13c. CITY OR TOWN Silver Spring.		13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
14. FATHER'S NAME FIRST MIDDLE LAST Franklin Hurdle.				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Albertha Pyles.				13e. STREET ADDRESS 11413 Columbia Pike S.S. MD.		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No.			16b. SOCIAL SECURITY NO. 214-80-2546		17. INFORMANT Mr. Herbert H. LaFourcade				13e. ADDRESS 13 e	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Nephrotic failure - renal failure 1579 DUE TO, OR AS A CONSEQUENCE OF (b) Chronic carcinomatous DUE TO, OR AS A CONSEQUENCE OF (c) obstruction of pancreas									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: no										
19a. DATE OF OPERATION 8/14 / 8/18/81			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED obstruct. jaundice - 65 yrs.			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) system					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 8/14 19 81 to 8/21 19 81 , that (I) (we) last saw the deceased alive on 8/20 19 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE M. C. CUNYEN			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8/21/81		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) M. C. CUNYEN			22e. ADDRESS 3915 Jackson Dr Wheaton							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial.			23b. DATE Aug. 25, 1981		23c. NAME OF CEMETERY OR CREMATORY Rock Creek, Rock Creek Ch. Rd.		23d. LOCATION CITY OR TOWN COUNTY STATE Washington, D. C.			
24. FUNERAL DIRECTOR W. H. D. G.			ADDRESS 254 Carroll Rd		25a. DATE REC'D. BY REGISTRAR AUG 25 1981		25b. REGISTRAR'S SIGNATURE James J. Harrison			

Washington, D. C. Jan. 6, 1907
Dear Sir,
I have the honor to acknowledge the receipt of your letter of the 1st inst. in relation to the matter of the proposed extension of the Washington and Annapolis Electric Railway Company.
The Board of Commissioners has considered the same and has decided to grant the extension of the line from the present terminus at the Navy Yard to the site of the proposed new terminus at the intersection of the line with the Annapolis and Poolesville Road.
The Board has also decided to grant the extension of the line from the present terminus at the Navy Yard to the site of the proposed new terminus at the intersection of the line with the Annapolis and Poolesville Road.
Very respectfully,
John D. Long
Chairman of the Board of Commissioners

Washington, D. C. Jan. 22, 1907
Dear Sir,
I have the honor to acknowledge the receipt of your letter of the 1st inst. in relation to the matter of the proposed extension of the Washington and Annapolis Electric Railway Company.
The Board of Commissioners has considered the same and has decided to grant the extension of the line from the present terminus at the Navy Yard to the site of the proposed new terminus at the intersection of the line with the Annapolis and Poolesville Road.
The Board has also decided to grant the extension of the line from the present terminus at the Navy Yard to the site of the proposed new terminus at the intersection of the line with the Annapolis and Poolesville Road.
Very respectfully,
John D. Long
Chairman of the Board of Commissioners

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 8121705			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Jack Boyd Lane, Sr.				2b. HOUR A M 9:30 A			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR August 17, 1923		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS HOURS MIN. 57	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) South Carolina		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD.	
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) The Clinical Center, NIH		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) general Superintendent		12b. KIND OF BUSINESS OR INDUSTRY Construction	
13a. STATE Maryland				13b. CITY OR TOWN Rockville		13c. STREET ADDRESS 4900 Ertter Drive	
14. FATHER'S NAME FIRST MIDDLE LAST John Humphrey Lane				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie Falkenberry			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes				16b. SOCIAL SECURITY NO. WW II 249-24-0498		17. INFORMANT ADDRESS Ruth Lane, wife Same	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY FAILURE 1580 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) RETROPERITONEAL LIPOSARCOMA METASTATIC TO DUE TO, OR AS A CONSEQUENCE OF (c) liver AND RIGHT HEMIDIAPHRAGM APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 28 July 81 , to 1 August 81 , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on 1 August 81 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (not) view the body after death.							
22b. SIGNATURE Jon K. Minford M.D.				DEGREE M.D.		22c. DATE SIGNED 8/1/81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jon K. Minford M.D.				22e. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Maryland			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/5/81		23c. NAME OF CEMETERY OR CREMATORY Parklawn Memorial Park		23d. LOCATION CITY OR TOWN COUNTY STATE Rockville, Maryland	
24. FUNERAL HOME Wheeler Funeral Home, Inc.				25a. DATE REC'D. BY REGISTRAR AUG 6 1981		25b. REGISTRAR'S SIGNATURE James J. [Signature]	
NAME 1331 Rockville Pike				ADDRESS Rockville, Maryland			

South Carolina USA

Montgomery

John

Hughes

Lane

Annie

Parkinson

Yes

WW II

1931
Rockville, Maryland
Funeral Home, Inc.
Parkinson Memorial Park, Rockville, Maryland

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8	1	2	1	7	0	6				
1- FOR STATE REGISTRAR										REG. NO.										
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Lillian M. LAPOINTE										2a. DATE OF DEATH MONTH DAY YEAR 8 8 81				2b. HOUR 11:15 AM						
3. SEX female			4. RACE Cauc.			5. DATE OF BIRTH MONTH DAY YEAR 5 24 11			6. AGE (IN YEARS (LAST BIRTHDAY)) 70 YRS			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) USA-Maine			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.											
10. CITY OR TOWN OF DEATH Silver Spring			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital							12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) US Navy			12b. KIND OF BUSINESS OR INDUSTRY Supervisor							
13a. STATE Md.										13b. COUNTY PG		13c. CITY OR TOWN Beltsville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 11327 Melclare Drive				
14. FATHER'S NAME FIRST MIDDLE LAST Louis M. LaPointe										15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Martha M. Dumais										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) None										16b. SOCIAL SECURITY NO. 006 18 0862		17. INFORMANT ADDRESS 11416 Montgomery Rd. Beltsville J. Claude LaPointe (Brother) Md.								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gleichenstoma Multiforme</u> 1919 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Feb 6 mos.										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)																				
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19					21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>					21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)					21f. LOCATION STREET CITY OR TOWN COUNTY STATE										
22a. I certify that (I) (this hospital) attended the deceased from <u>Feb</u> 19 <u>81</u> to <u>Aug 8</u> 19 <u>81</u> , that (I) (we) last saw the deceased alive on <u>Aug 8</u> 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																				
22b. SIGNATURE Robert L. Rosenberg										DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 8/8/81					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ROBERT L. ROSENBERG, MD										22e. ADDRESS 1131 UNIVERSITY BLVD., W., SILVERSPRING, MD.										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial					23b. DATE 8/11/81		23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet					23d. LOCATION CITY OR TOWN COUNTY STATE Washington D.C.								
24. FUNERAL DIRECTOR NAME Hines/Rinaldi										F.H. 11800		N.H. Ave. S.S. Md.					25a. DATE REC'D. BY REGISTRAR AUG 12 1981		25b. REGISTRAR'S SIGNATURE [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

BP

DHMM-16 30M 2/80
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 2 1 7 0 7

1. FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (Type or print) EDWARD W Laughlin			2a. DATE OF DEATH MONTH DAY YEAR 8 13 81		2b. HOUR 5 A M
3. SEX M ale	4. RACE W hite	5. DATE OF BIRTH MONTH DAY YEAR 10 2 1919		6. AGE (IN YEARS LAST BIRTHDAY) 61 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS: HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PA.	7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.
10. CITY OR TOWN OF DEATH Belhesda	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hoop. Asso c			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Illustrator	
13a. STATE DC.			13b. CITY OR TOWN Washington	13c. STREET ADDRESS 5330 42nd St. N.W.	
14. FATHER'S NAME FIRST MIDDLE LAST Thomas Laughlin			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Delia Keady		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II		17. INFORMANT ADDRESS Dorothy L. Werner 4557 Windsor Beth. Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 1889 IMMEDIATE CAUSE (a) Hyperkalemia DUE TO, OR AS A CONSEQUENCE OF (b) renal failure DUE TO, OR AS A CONSEQUENCE OF (c) metastatic Transitional Cell CA Bladder					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 week 1 month 1 year
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from Aug 11 19 81 to Aug 12 19 81 , that (I) (we) last saw the deceased alive on Aug 12 19 81 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Edward C. Gilbert		DEGREE M.D.		22c. DATE SIGNED Aug 13, 81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) EDWARD C. Gilbert		22e. ADDRESS 9801 Georgia Ave. Silver Spr. Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Aug. 18, 1981		23c. NAME OF CEMETERY OR CREMATORY Union Cemetery	
23d. LOCATION CITY OR TOWN COUNTY STATE New Kensington Prince Georges		23e. DATE OF RECORD AUG 20 1981			
24. FUNERAL DIRECTOR NAME John F. DeVol		ADDRESS WASH. D.C.			

Continued

March 1, 1944

Yours

Chas. G. Smith

Vol. II

12

13

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

REG. NO.

1 - FOR
STATE
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) Joseph R. Leakins			2a DATE OF DEATH MONTH DAY YEAR Aug. 25, 1981			2b HOUR 10:12 PM				
3 SEX Male		4 RACE Caucasian		5 DATE OF BIRTH DAY MONTH YEAR May 16 1902		6 AGE (IN YEARS LAST BIRTHDAY) 79		7a IF UNDER 1 YEAR MONTHS DAYS YRS		
7b BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7c CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery				
10 CITY OR TOWN OF DEATH Olney		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery General Hospital				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Farmer		12b KIND OF BUSINESS OR INDUSTRY		
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE 13b COUNTY Md. Howard			13c INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d STREET ADDRESS 1720 St. Michaels Rd.					
14 FATHER'S NAME FIRST MIDDLE LAST Gaither G. Leakins			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Virginia L. Warfield							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO. 215-10-2659		17 INFORMANT Ronnie J. Leakins		ADDRESS Item 13				
18 CAUSE OF DEATH (Enter only one cause per line (a), (b) and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiac Arrest 2500 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF Staphylococcus aureus DUE TO, OR AS A CONSEQUENCE OF Staphylococcus aureus PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 Sept. 2, died probably due to Ch. of Colon									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH years	
19a DATE OF OPERATION 8/25			19b CONDITION FOR WHICH OPERATION WAS PERFORMED Ch. of Colon			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d INJURY OCCURRED WHERE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE 70 8/25 81						
22a I certify that (1) (this hospital) attended the deceased from 8/25 19 81 , and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (If one (did) not view the body after death.									22c DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
22b SIGNATURE R. H. Leakins				22e ADDRESS 1811 P. R. Philip Dr Olney				22c D. SIGNED 8/26/81		
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 8/28/81		23c NAME OF CEMETERY OR CREMATORY Pine Grove		23d LOCATION CITY OR TOWN COUNTY STATE Mt. Airy, Carroll, Md.				
24 FUNERAL DIRECTOR NAME ADDRESS Olin L. Molesworth, P.A., Damascus, Md.				25a DATE REC'D. BY REGISTRAR AUG 26 1981		25b REGISTRAR'S SIGNATURE James J. Nathan				

BP
DHMH - 16 60M / 175
(VR A 15 (4))

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office of the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

DHMH - 16 60M 1/75
(VR A 15 (4))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
DECEASED NAME (TYPE OR PRINT)		MONTH DAY YEAR		MONTH DAY YEAR	
ERWIN L. LeCLERG		August 3, 1981		6:32pm	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR	
MALE	CAUCASIAN	MONTH DAY YEAR	80 YRS	IF UNDER 24 HRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
MISSOURI	U.S.A.		Montgomery MD		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY		
Olney	Montgomery General Hospital	STATISTICIAN	U.S. DEPT OF AGR		
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
MARYLAND	MONTGOMERY	SILVER SPRING	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	14620 DEERHURST TERRACE	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME			
FIRST MIDDLE LAST		FIRST MIDDLE LAST			
CHARLES FRANK LeCLERG		LILLIAN DUNN			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO	17. INFORMANT ADDRESS		
NO		213-38-3058	PHYLIS R. LeCLERG SAME AS 13 WIFE		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a):					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2030 Gastrointestinal Hemorrhage					2 weeks
DUE TO, OR AS A CONSEQUENCE OF (b):					3 years
Multiple Myeloma					
DUE TO, OR AS A CONSEQUENCE OF (c):					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
		P.M. 19			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from Aug 3, 1981, to Aug 3, 1981, that (I) (we) last saw the deceased alive on Aug 3, 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
Eugene P. Flannery		MD		3 Aug 81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
EUGENE P. FLANNERY		1811 PRINCE PHILIP DR. OLNEY, MD. 20832			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE
BURIAL		8/7/81	FT. LINCOLN		BRENTWOOD PRI GEO MD.
24. FUNERAL DIRECTOR NAME		24b. ADDRESS		25a. DATE REC'D. BY REGISTRAR REGISTRAR'S SIGNATURE	
FRANCIS J. COLLINS		500 UNIV. BLVD. W. SILVER SPRING, MD. 20901		AUG 7 1981	

1900-1901

RECEIVED

1900-1901

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RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 1 2 1 7 1 0	
1 - FOR STATE REGISTRAR				REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MARY ANN LEISTER			2a. DATE OF DEATH MONTH DAY YEAR AUGUST 23 81		2b. HOUR 5:15 AM
3 SEX FEMALE	4 RACE WHITE	5. DATE OF BIRTH JUNE 26 35		6 AGE (IN YEARS LAST BIRTHDAY) 46	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10 CITY OR TOWN OF DEATH ROCKVILLE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN U.S. CITY, GIVE STREET ADDRESS) 14308 WOODCREST DR		9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) COMPUTER TECH.		12b. KIND OF BUSINESS OR INDUSTRY H.E.W.			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) MD			13b. CITY OR TOWN MONTGOMERY		13c. STREET ADDRESS 14308 WOODCREST DR
14. FATHER'S NAME FIRST MIDDLE LAST HECTOR SNYDER		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY BRAUN			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 217-30-4572		17 INFORMANT NAME ADDRESS C. RICHARD LEISTER SAME AS 13E	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 1749 Metastatic Breast Cancer IMMEDIATE CAUSE (a) Breast Cancer DUE TO, OR AS A CONSEQUENCE OF (b) Breast Cancer DUE TO, OR AS A CONSEQUENCE OF (c) Breast Cancer Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)					
19a. DATE OF OPERATION Aug. 1979		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Breast Cancer		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from Oct 15, 19 80 to 23 Aug, 19 81 , that (I) (we) last saw the deceased alive on 23 Aug, 19 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE E. P. Libre MD				22c. DATE SIGNED AUG. 24, 1981	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) EUGENE P. LIBRE				22e. ADDRESS 10400 CONN. AVE., KENSINGTON, MD	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 8-26-81		23c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN CEM	
23d. LOCATION CITY OR TOWN COUNTY STATE SILVER SPRING MONT, MD		23e. DATE REC'D. BY REGISTRAR OR REGISTRAR'S SIGNATURE AUG 25 1981			
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS					

Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours of the death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8121711 REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) Oren L Lentz				2a. DATE OF DEATH MONTH DAY YEAR August 12, 1981				2b. HOUR * 6:30 A.M.					
3. SEX Male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR May 22 1906		6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 74 HRS			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD.							
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Printer		12b. KIND OF BUSINESS OR INDUSTRY Operator Linotype			
13a. STATE Maryland				13b. COUNTY Montgomery		13c. CITY OR TOWN Sil. Spring		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS 304 E. Franklin Avenue,	
14. FATHER'S NAME FIRST MIDDLE LAST Chauncey Lentz				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary B. Shumaker									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) \$77-10-8051		17. INFORMANT ADDRESS Ruth W. Lentz-wife- (same as 13e)							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest - Respiratory Failure</u> 4960 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Chronic Obstructive Pulmonary Disease</u> 4960 DUE TO, OR AS A CONSEQUENCE OF (c) <u>Chronic Obstructive Pulmonary Disease</u> 4960 Approximate Interval Between Onset and Death: <u>immediate</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>immediate</u>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Generalized Atherosclerosis</u>													
19a. DATE OF OPERATION 7/14/81		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Ruptured Abdominal Aortic Aneurysm				20a. AUTOPSY? NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (the hospital) attended the deceased from 7/14 to 8/12, 1981, that (I) (we) saw the deceased alive on 8/11, 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE Marvin L. Kolkin, MD				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 9/12/81					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Marvin L. Kolkin, MD				22e. ADDRESS 11811 Pr. Phillip Dr., Olney, Md.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8-14-1981		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln				23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood Montgomery Md.					
24. FUNERAL DIRECTOR'S NAME Warner E. Pumphrey, Inc. 8434 Ga. Ave., S.S. Md.				25a. DATE REC'D. BY REGISTRAR AUG 17 1981								25b. REGISTRAR'S SIGNATURE Name of Registrar	

1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 2 1 7 1 2

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) MORTON B. LEVIN			2a. DATE OF DEATH MONTH DAY YEAR 8-13-1981			2b. HOUR 9:30 AM			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR June 14, 1916		6. AGE (IN YEARS (LAST BIRTHDAY)) 65 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.			
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Govt. Emp. (Ret.)		12b. KIND OF BUSINESS OR INDUSTRY US Govt.	
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Chevy Chase		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 4701 Willard Avenue	
14. FATHER'S NAME FIRST MIDDLE LAST Augustus Levin				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Minnie Lipman					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes WW II				16b. SOCIAL SECURITY NO. 233-14-6604		17. INFORMANT ADDRESS Mildred Levin; 4701 Willard Ave.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Adenocarcinoma of the Lung 1629 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) GI Bleeding; Pneumonia									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (a) (this hospital) attended the deceased from 8/5 19 81 , to 8/13 19 81 , that (b) (we) lost saw the deceased alive on 8/13 19 81 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (did) (did not) view the body after death.									
22b. SIGNATURE Robert H Blee MD					DEGREE		22c. DATE SIGNED 8/13/81		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert H Blee MD					22e. ADDRESS 7315 Wisconsin Ave, #915N, Bethesda				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 8-14-81		23c. NAME OF CEMETERY OR CREMATORY King David Mem. Garden		23d. LOCATION CITY OR TOWN COUNTY STATE Falls Church, Virginia		
24. FUNERAL DIRECTOR NAME ADDRESS Danzansky-Goldberg Chapels; 1170 Rockville Pike					25a. DATE REC'D. BY REGISTRAR AUG 17 1981				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 21 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

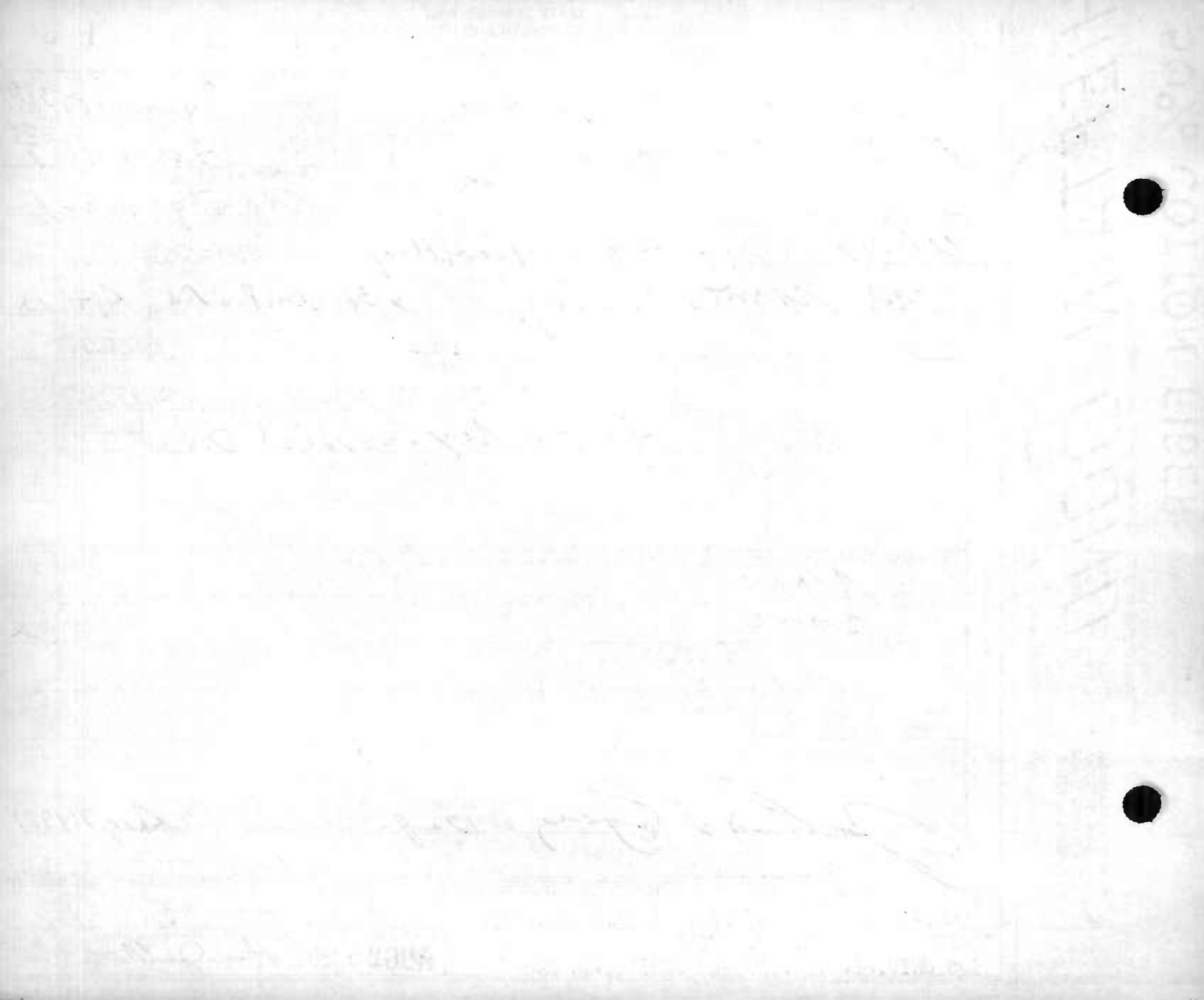
Dr. Ball Baker body

5600 BP



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE DEATH CERTIFICATE. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 21713	
1. DECEASED NAME (TYPE OR PRINT) Shirley A. Lewin							2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR Aug 21 1981		2b. HOUR OF DEATH 8:30		
3. SEX F		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR Sept 13 1944		6. AGE (IN YEARS) LAST BIRTHDAY YRS. 34		IF UNDER 1 YR. MONTHS DAYS HOURS MIN		7c. DATE PRONOUNCED DEAD Aug 21 1981	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) INDIANA			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.		
10. CITY OR TOWN OF DEATH Olney			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery Gen. Hosp				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) REAL ESTATE SALES AGENT			12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MD			13b. COUNTY Montgomery		13c. CITY OR TOWN S. 1. Spg.		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 3410 Belvue Rd., Apt 18		
14. FATHER'S NAME FIRST MIDDLE LAST HORACE S. SHAW				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST IRENE ARMSTRONG							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 228-42-2723		17. INFORMANT ADDRESS JOHN THOMAS LEWIN SAME AS 13 HUSBAND					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Dis. 4291 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: None											
19a. DATE OF OPERATION None				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE John S. Rogers				TITLE (SPECIFY) Def. M.D. Def. MEDICAL EXAMINER				DATE Aug 24/1981			
EXAMINER'S NAME (TYPE OR PRINT) JOHN S. ROGERS				ADDRESS 1919 SEMINARY ROAD, SILVER SPRING, MD.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 8/25/81		23c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN			23d. LOCATION CITY OR TOWN COUNTY STATE SILVER SPRING, MONT MD.			
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS						25a. DATE REC'D. BY REGISTRAR AUG 25 1981 REGISTRAR'S SIGNATURE James J. Heston					
500 UNIV. BLVD., W., SILVER SPRING, MD. 20901											



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA 3. RETAIN PAGE 5 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

FOR 1- STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										21714 REG. NO.							
1. DECEASED NAME (TYPE OR PRINT) Ruth Ademp L'Homme dieu												2b. DATE KNOWN OF DEATH MONTH DAY YEAR Aug 23 1981		2c. DATE OF ESTI- MATED DEATH MONTH DAY YEAR Aug 23 1981					
3. SEX F		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 11 22 05		6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR Aug 23 1981		7d. HOUR 10:00 AM PM					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASH, D.C.				7b. CITIZEN OF WHAT COUNTRY? U.S.A				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.							
10. CITY OR TOWN OF DEATH Silver Spring				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 9203 2nd Ave.								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) AT HOME				12b. KIND OF BUSINESS OR INDUSTRY HOUSE WIFE			
13a. STATE MD												13b. COUNTY Mont.		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 9203 2nd Ave	
14. FATHER'S NAME FIRST MIDDLE LAST UNKNOWN												15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST UNKNOWN							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 721-03-5048				17. INFORMANT JOHN L'HOME DIEU				ADDRESS 9203-2nd Ave, SILVER SPRING MD.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Inf. DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. 4291 (b) Chronic Myocardial Inf DUE TO, OR AS A CONSEQUENCE OF (c) 4 yr APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 yr																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). None																			
19a. DATE OF OPERATION None				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																			
ACTUAL SIGNATURE [Signature]				TITLE (SPECIFY) Dep. M.D.				MEDICAL EXAMINER				DATE SIGNED Aug 23 1981							
EXAMINER'S NAME (TYPE OR PRINT) JOHN S. ROGERS				ADDRESS SILVER SPRING, MD.															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION				23b. DATE 8/24/81				23c. NAME OF CEMETERY OR CREMATORY LEE CREMATORY				23d. LOCATION CITY OR TOWN COUNTY STATE WASH, D.C.							
24. FUNERAL DIRECTOR NAME HINES RINALDI				ADDRESS SILVER SPRING, MD				25a. DATE REC'D. BY REGISTRAR AUG 26 1981				25b. REGISTRAR'S SIGNATURE [Signature]							

RECEIVED AT THE OFFICE OF THE
DIRECTOR OF THE BUREAU OF
THE ARMY AND NAVAL STORES

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AUG 2 1961

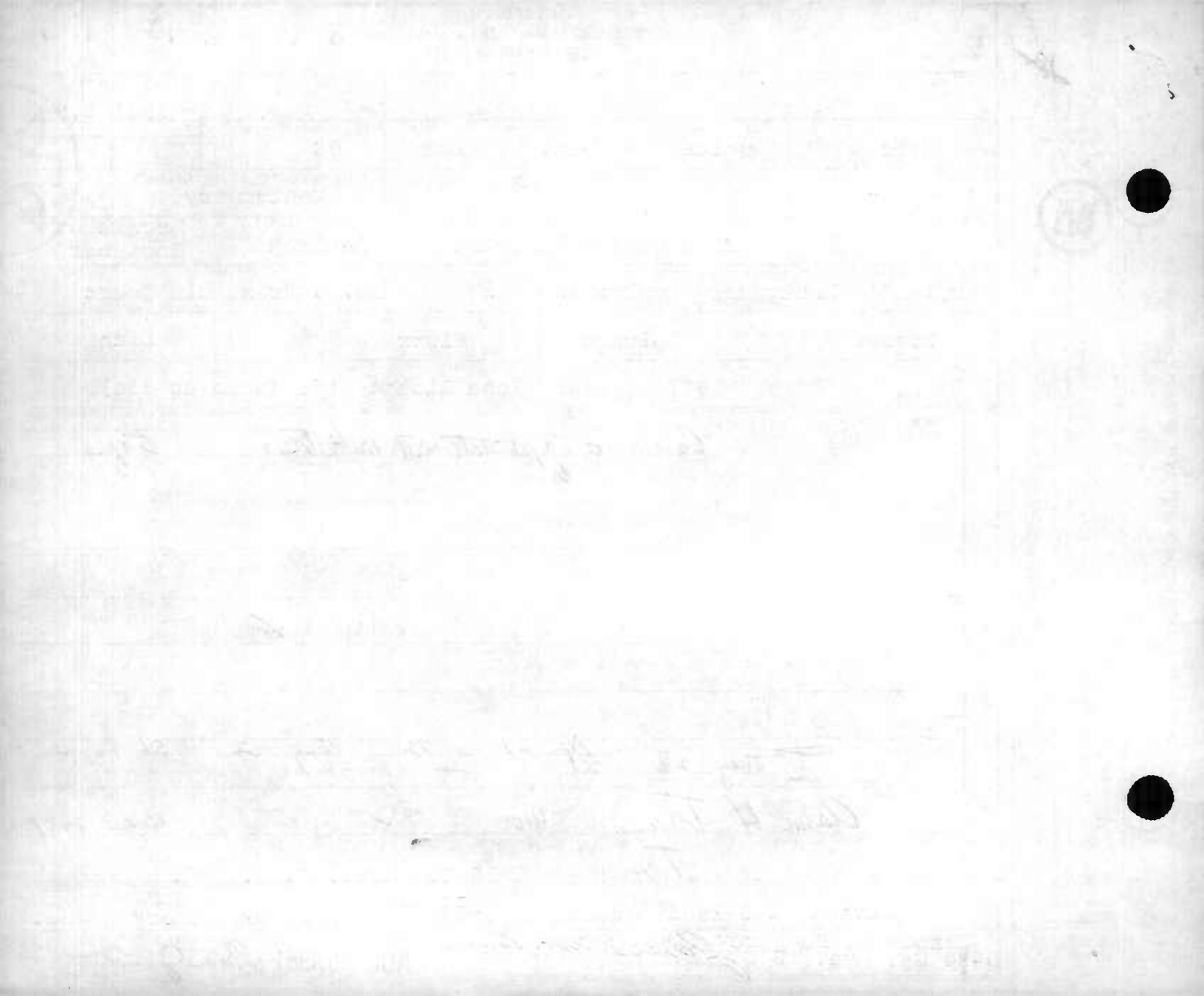
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE						8 1 2 1 7 1 5		
1. FOR STATE REGISTRAR						REG. NO.		
1. DECEASED NAME (TYPE OR PRINT) Zaki Lichaa			2a. DATE OF DEATH MONTH DAY YEAR Aug. 2 1981		2b. HOUR 2:P M			
3. SEX Male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR Oct. 8, 1902		6. AGE (IN YEARS LAST BIRTHDAY) 78		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Egypt		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.		
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF IN NURSING HOME, GIVE STREET ADDRESS) 12207 Braxfield Court			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired Architect Engineer			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Yossef Lichaa		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Florr Lichaa						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 577-86-2809		17. INFORMANT ADDRESS Rose Lichaa-wife-(same as 13e)				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of prostate with metastasis 1850 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 yrs		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (the normal MD 27) attended the deceased from July 23 , 19 81 , to Aug 2 , 19 81 , that (I) (we) lost saw the deceased alive on July 23 , 19 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE Aaron H. Trau		DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED Aug 3 1981		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) AARON H. TRAU MD		22e. ADDRESS 8915 Ga. Ave., S. S., Md.						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8-3-1981		23c. NAME OF CEMETERY OR CREMATORY Judean Memorial Gardens		23d. LOCATION CITY OR TOWN COUNTY STATE Olney Montgomery Md.		
24. FUNERAL DIRECTOR Warner E. Pumphrey, Inc. 8434 Ga. Ave., S.S., Md.				25a. DATE REC'D. BY REGISTRAR AUG 5 1981		25b. REGISTRAR'S SIGNATURE James J. Martin		



1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		FIRST		MONTH		DAY		YEAR		2b. HOUR	
Ernest L. Linthicum								2a. DATE KNOWN OF DEATH		8		20		1981				2b. HOUR	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR	
Male		White		Apr. 2, 1914		67 YRS.		MONTHS		DAYS		HOURS		MIN.		8		26	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH													
Virginia		USA		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		Montgomery													
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY													
Silver Spring		625 Ray Drive		Salesman		Premier Furniture Co.													
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS											
Maryland		Montgomery		Sil. Spring,		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		625 Ray Drive,											
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME																	
Ernest J. Linthicum		Emma L. DeLung																	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS													
no		577-07-9484		(son)		4233 Stafford													
				Robert T. Linthicum-Rd.,		Olney, Md.													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		Left Subdural Hematoma		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH													
88880		DUE TO, OR AS A CONSEQUENCE OF																	
Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last.		(b)		DUE TO, OR AS A CONSEQUENCE OF															
		(c)																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).																			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?													
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>													
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR ? P.M. 8 16 1981		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE									
		Home		625 Ray Drive		Silver Spring		Montgomery Co.,		Maryland									
22a. I certify that I took charge of the remains described above, held an		Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion																	
death resulted from:		Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																	
ACTUAL SIGNATURE		Virginia L. Dolan		TITLE (SPECIFY) M.D. Assistant		MEDICAL EXAMINER		DATE SIGNED		8-27-81									
EXAMINER'S NAME (TYPE OR PRINT)		Virginia L. Dolan, M.D.		ADDRESS		111 Penn Street													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		COUNTY		STATE									
Burial		9-1-1981		Cedar Hill Cemetery		Suitland Pr.		Georges, Md.											
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE															
Walter E. Pumphrey, Inc.		8434 Ga. Ave., S.S. Md.																	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE MEDICAL EXAMINER SHOULD SIGN AND DATE THIS CERTIFICATE. PAGES 1, 2, AND 3 TO THE FUNERAL PERMIT, PAGES 4, 5, AND 6 TO THE FUNERAL PERMIT, PAGES 7, 8, AND 9 TO THE FUNERAL PERMIT, PAGES 10, 11, AND 12 TO THE FUNERAL PERMIT, PAGES 13, 14, AND 15 TO THE FUNERAL PERMIT, PAGES 16, 17, AND 18 TO THE FUNERAL PERMIT, PAGES 19, 20, AND 21 TO THE FUNERAL PERMIT, PAGES 22, 23, AND 24 TO THE FUNERAL PERMIT, PAGES 25, 26, AND 27 TO THE FUNERAL PERMIT, PAGES 28, 29, AND 30 TO THE FUNERAL PERMIT, PAGES 31, 32, AND 33 TO THE FUNERAL PERMIT, PAGES 34, 35, AND 36 TO THE FUNERAL PERMIT, PAGES 37, 38, AND 39 TO THE FUNERAL PERMIT, PAGES 40, 41, AND 42 TO THE FUNERAL PERMIT, PAGES 43, 44, AND 45 TO THE FUNERAL PERMIT, PAGES 46, 47, AND 48 TO THE FUNERAL PERMIT, PAGES 49, 50, AND 51 TO THE FUNERAL PERMIT, PAGES 52, 53, AND 54 TO THE FUNERAL PERMIT, PAGES 55, 56, AND 57 TO THE FUNERAL PERMIT, PAGES 58, 59, AND 60 TO THE FUNERAL PERMIT, PAGES 61, 62, AND 63 TO THE FUNERAL PERMIT, PAGES 64, 65, AND 66 TO THE FUNERAL PERMIT, PAGES 67, 68, AND 69 TO THE FUNERAL PERMIT, PAGES 70, 71, AND 72 TO THE FUNERAL PERMIT, PAGES 73, 74, AND 75 TO THE FUNERAL PERMIT, PAGES 76, 77, AND 78 TO THE FUNERAL PERMIT, PAGES 79, 80, AND 81 TO THE FUNERAL PERMIT, PAGES 82, 83, AND 84 TO THE FUNERAL PERMIT, PAGES 85, 86, AND 87 TO THE FUNERAL PERMIT, PAGES 88, 89, AND 90 TO THE FUNERAL PERMIT, PAGES 91, 92, AND 93 TO THE FUNERAL PERMIT, PAGES 94, 95, AND 96 TO THE FUNERAL PERMIT, PAGES 97, 98, AND 99 TO THE FUNERAL PERMIT, PAGES 100, 101, AND 102 TO THE FUNERAL PERMIT, PAGES 103, 104, AND 105 TO THE FUNERAL PERMIT, PAGES 106, 107, AND 108 TO THE FUNERAL PERMIT, PAGES 109, 110, AND 111 TO THE FUNERAL PERMIT, PAGES 112, 113, AND 114 TO THE FUNERAL PERMIT, PAGES 115, 116, AND 117 TO THE FUNERAL PERMIT, PAGES 118, 119, AND 120 TO THE FUNERAL PERMIT, PAGES 121, 122, AND 123 TO THE FUNERAL PERMIT, PAGES 124, 125, AND 126 TO THE FUNERAL PERMIT, PAGES 127, 128, AND 129 TO THE FUNERAL PERMIT, PAGES 130, 131, AND 132 TO THE FUNERAL PERMIT, PAGES 133, 134, AND 135 TO THE FUNERAL PERMIT, PAGES 136, 137, AND 138 TO THE FUNERAL PERMIT, PAGES 139, 140, AND 141 TO THE FUNERAL PERMIT, PAGES 142, 143, AND 144 TO THE FUNERAL PERMIT, PAGES 145, 146, AND 147 TO THE FUNERAL PERMIT, PAGES 148, 149, AND 150 TO THE FUNERAL PERMIT, PAGES 151, 152, AND 153 TO THE FUNERAL PERMIT, PAGES 154, 155, AND 156 TO THE FUNERAL PERMIT, PAGES 157, 158, AND 159 TO THE FUNERAL PERMIT, PAGES 160, 161, AND 162 TO THE FUNERAL PERMIT, PAGES 163, 164, AND 165 TO THE FUNERAL PERMIT, PAGES 166, 167, AND 168 TO THE FUNERAL PERMIT, PAGES 169, 170, AND 171 TO THE FUNERAL PERMIT, PAGES 172, 173, AND 174 TO THE FUNERAL PERMIT, PAGES 175, 176, AND 177 TO THE FUNERAL PERMIT, PAGES 178, 179, AND 180 TO THE FUNERAL PERMIT, PAGES 181, 182, AND 183 TO THE FUNERAL PERMIT, PAGES 184, 185, AND 186 TO THE FUNERAL PERMIT, PAGES 187, 188, AND 189 TO THE FUNERAL PERMIT, PAGES 190, 191, AND 192 TO THE FUNERAL PERMIT, PAGES 193, 194, AND 195 TO THE FUNERAL PERMIT, PAGES 196, 197, AND 198 TO THE FUNERAL PERMIT, PAGES 199, 200, AND 201 TO THE FUNERAL PERMIT, PAGES 202, 203, AND 204 TO THE FUNERAL PERMIT, PAGES 205, 206, AND 207 TO THE FUNERAL PERMIT, PAGES 208, 209, AND 210 TO THE FUNERAL PERMIT, PAGES 211, 212, AND 213 TO THE FUNERAL PERMIT, PAGES 214, 215, AND 216 TO THE FUNERAL PERMIT, PAGES 217, 218, AND 219 TO THE FUNERAL PERMIT, PAGES 220, 221, AND 222 TO THE FUNERAL PERMIT, PAGES 223, 224, AND 225 TO THE FUNERAL PERMIT, PAGES 226, 227, AND 228 TO THE FUNERAL PERMIT, PAGES 229, 230, AND 231 TO THE FUNERAL PERMIT, PAGES 232, 233, AND 234 TO THE FUNERAL PERMIT, PAGES 235, 236, AND 237 TO THE FUNERAL PERMIT, PAGES 238, 239, AND 240 TO THE FUNERAL PERMIT, PAGES 241, 242, AND 243 TO THE FUNERAL PERMIT, PAGES 244, 245, AND 246 TO THE FUNERAL PERMIT, PAGES 247, 248, AND 249 TO THE FUNERAL PERMIT, PAGES 250, 251, AND 252 TO THE FUNERAL PERMIT, PAGES 253, 254, AND 255 TO THE FUNERAL PERMIT, PAGES 256, 257, AND 258 TO THE FUNERAL PERMIT, PAGES 259, 260, AND 261 TO THE FUNERAL PERMIT, PAGES 262, 263, AND 264 TO THE FUNERAL PERMIT, PAGES 265, 266, AND 267 TO THE FUNERAL PERMIT, PAGES 268, 269, AND 270 TO THE FUNERAL PERMIT, PAGES 271, 272, AND 273 TO THE FUNERAL PERMIT, PAGES 274, 275, AND 276 TO THE FUNERAL PERMIT, PAGES 277, 278, AND 279 TO THE FUNERAL PERMIT, PAGES 280, 281, AND 282 TO THE FUNERAL PERMIT, PAGES 283, 284, AND 285 TO THE FUNERAL PERMIT, PAGES 286, 287, AND 288 TO THE FUNERAL PERMIT, PAGES 289, 290, AND 291 TO THE FUNERAL PERMIT, PAGES 292, 293, AND 294 TO THE FUNERAL PERMIT, PAGES 295, 296, AND 297 TO THE FUNERAL PERMIT, PAGES 298, 299, AND 300 TO THE FUNERAL PERMIT, PAGES 301, 302, AND 303 TO THE FUNERAL PERMIT, PAGES 304, 305, AND 306 TO THE FUNERAL PERMIT, PAGES 307, 308, AND 309 TO THE FUNERAL PERMIT, PAGES 310, 311, AND 312 TO THE FUNERAL PERMIT, PAGES 313, 314, AND 315 TO THE FUNERAL PERMIT, PAGES 316, 317, AND 318 TO THE FUNERAL PERMIT, PAGES 319, 320, AND 321 TO THE FUNERAL PERMIT, PAGES 322, 323, AND 324 TO THE FUNERAL PERMIT, PAGES 325, 326, AND 327 TO THE FUNERAL PERMIT, PAGES 328, 329, AND 330 TO THE FUNERAL PERMIT, PAGES 331, 332, AND 333 TO THE FUNERAL PERMIT, PAGES 334, 335, AND 336 TO THE FUNERAL PERMIT, PAGES 337, 338, AND 339 TO THE FUNERAL PERMIT, PAGES 340, 341, AND 342 TO THE FUNERAL PERMIT, PAGES 343, 344, AND 345 TO THE FUNERAL PERMIT, PAGES 346, 347, AND 348 TO THE FUNERAL PERMIT, PAGES 349, 350, AND 351 TO THE FUNERAL PERMIT, PAGES 352, 353, AND 354 TO THE FUNERAL PERMIT, PAGES 355, 356, AND 357 TO THE FUNERAL PERMIT, PAGES 358, 359, AND 360 TO THE FUNERAL PERMIT, PAGES 361, 362, AND 363 TO THE FUNERAL PERMIT, PAGES 364, 365, AND 366 TO THE FUNERAL PERMIT, PAGES 367, 368, AND 369 TO THE FUNERAL PERMIT, PAGES 370, 371, AND 372 TO THE FUNERAL PERMIT, PAGES 373, 374, AND 375 TO THE FUNERAL PERMIT, PAGES 376, 377, AND 378 TO THE FUNERAL PERMIT, PAGES 379, 380, AND 381 TO THE FUNERAL PERMIT, PAGES 382, 383, AND 384 TO THE FUNERAL PERMIT, PAGES 385, 386, AND 387 TO THE FUNERAL PERMIT, PAGES 388, 389, AND 390 TO THE 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517, 518, AND 519 TO THE

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MEDICAL CERTIFICATION





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
1- FOR STATE REGISTRAR					8 1 2 1 7 1 7				
1 DECEASED NAME (TYPE OR PRINT)					2a DATE OF DEATH				
Beau Janeze Little					August 14, 1981				
3. SEX		4. RACE		5. DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		7b HOUR	
Female		Black		August 14, 1981		August 14, 1981		1:55pm	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH		10b HOUR	
TAKOMA PARK		U.S.A.				MONTGOMERY		3 4	
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		MD	
TAKOMA PARK		Washington Adventist Hospital							
13a STATE		13b COUNTY		13c. INSIDE CITY LIMITS?		13d STREET ADDRESS			
Maryland		PG		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		10C North Manor Circle #4			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME							
John Russell Little		Diane Boone							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO.		17 INFORMANT		ADDRESS			
				Mother: 10C North Manor Circle #4 T.P., MD					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <u>Respiratory Failure</u>									
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Prematurity 25 weeks</u>									
DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)									
<u>Maternal Premature Labor</u>									
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY?		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
		P.M. 19							
21d INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION		CITY OR TOWN		COUNTY STATE	
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				STREET					
22a I certify that (I) (this hospital) attended the deceased from <u>8/1/81</u> to <u>8/14/81</u> , that (I) (we) last saw the deceased alive on <u>8/1/81</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED			
<u>Aurora A. Perez</u>		M.D.				<u>8/21/81</u>			
22d PHYSICIAN'S NAME (TYPE OR PRINT)		22e ADDRESS							
AURORA A. PEREZ		11014 NEW HAMPSHIRE, SS, MD.							
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d LOCATION			
Cremation		8-24-81		WASH		TAKOMA PARK		COUNTY STATE	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
NAME ADDRESS		SEP 2 1981		<u>Aurora A. Perez</u>					
<u>H Shipomz</u>		<u>7600 Carroll Ave.</u>							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
CERTIFICATE OF DEATH									
1. FOR - STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH				
FIRST MIDDLE LAST ENID B LOAN					MONTH DAY YEAR HOUR August 25, 81 11:45 PM				
3. SEX		4 RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7b. HOUR	
Female		White		MONTH DAY YEAR June 24, 1880		101 YRS		11:45 PM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
N.Y.		US				Montgomery MD			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Chevy Chase		8607 Woodbrook Lane		Teacher		School			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
Md.		Montgomery		Chevy Chase		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		8607 Woodbrook Lane	
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST					
Frank L. Butts				Hattie A. Greene					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS			
No		215-46-1534		Ruth B. Tapke Sister		Ch.Ch., Md. 8609 Woodbrook La.			
18. CAUSE OF DEATH (Enter only one cause for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic long standing heart failure 4140 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic obstructive heart disease DUE TO, OR AS A CONSEQUENCE OF (c) 35 months memory failure.									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) Mitral regurgitation reaction.									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY STATE	
22a. I certify that (I) (the deceased) attended the deceased from August 19, 81, to August 25, 81, that (I) (we) lost the deceased alive on August 25, 81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death.)									
22b. SIGNATURE		22c. DEGREE		22d. ATTENDING PHYSICIAN		22e. MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22f. DATE SIGNED	
George A. Gray, M.D.				6917 Arlington Blvd., Bethesda, Md.				August 26, 81	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Cremation		8/27/81		Cedar Hill Crematory		Suitland, Md.			
24. FUNERAL DIRECTOR NAME				24b. ADDRESS		25a. RECEIVED BY REGISTRAR			
Joseph Gawler's Sons, Inc.				5130 Wisc. Ave. N.W. Wash., D.C. 20016		SEP 01 1981			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR				REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) FANNIE LONG				2a. DATE OF DEATH MONTH DAY YEAR AUG. 10, 1981				2b. HOUR M	
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR JAN. 29, 1889		6. AGE (IN YEARS LAST BIRTHDAY) 92 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VA.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.			
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CHEVY CHASE NURSING HOME				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md.				13b. COUNTY Montg.		13c. CITY OR TOWN Barthersburg		13d. STREET ADDRESS 21311 Burnham Ave	
14. FATHER'S NAME FIRST MIDDLE LAST ROBERT MARTIN				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lucy A. LAWSON					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 224-16-6158		17. INFORMANT ADDRESS Lucy Boyd (daughter) SAME AS #13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 4059 DUE TO, OR AS A CONSEQUENCE OF (b) Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF (c) 10 years								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): Status post amputation Below Knee on RT.									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) (the deceased) attended the deceased from Jan 78 19 81 , to 8/10 19 81 , that (1) (was) lost saw the deceased alive on 7/29 19 81 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Lawrence J. Thomas M.D.						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8/10/81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) LAWRENCE J. THOMAS				22e. ADDRESS 11801 ROCKVILLE PIKE					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 8-13-81		23c. NAME OF CEMETERY OR CREMATORY LAMBERT CEM.		23d. LOCATION CITY OR TOWN COUNTY STATE WARRENTON VA.			
24. FUNERAL DIRECTOR NAME GEORGE R. SNOWDEN				24b. ADDRESS 246 N. WASH. ST. ROCKVILLE MD		25a. DATE REC'D. BY REGISTRAR AUG 10 1981		25b. REGISTRAR'S SIGNATURE James J. [Signature]	

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8 1 2 1 7 2 0	
1- FOR STATE REGISTRAR				CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)						2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
Frances Loomis						Aug. 22, 1981				11:37 AM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Female		White		March 26, 1896		85 YRS.		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Michigan		U.S.A.				Montgomery MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Rockville		Collingswood Nursing Home				Librarian		Govt.			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		2319 40th Plave, N.W.			
14. FATHER'S NAME						15. MOTHER'S MAIDEN NAME					
FIRST MIDDLE LAST		FIRST MIDDLE LAST		FIRST MIDDLE LAST		FIRST MIDDLE LAST		FIRST MIDDLE LAST		FIRST MIDDLE LAST	
Arthur P. Loomis		P. Loomis		(Unknown)							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
No				362-32-0721		Walter Knauff-2326 19th St., N.W.-Wash., D.C.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:										Years	
IMMEDIATE CAUSE (a) Congestive Heart Failure											
4280 DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
				P.M. 19							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 8/19, 1981, to 8/22, 1981, that (I) (we) last saw the deceased alive on 8/19, 1981, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If "did not view the body after death" is checked, the signature of the medical examiner is required.)											
22b. SIGNATURE				DEGREE				22c. DATE SIGNED			
Alfred Muller								8/22/81			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS					
Alfred Muller						3301 New Mexico Ave., NW, Washington, D.C.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Removal-Burial				8/25/81		Balcom Cemetery		Berlin Township, Ionia, Mich.			
24. FUNERAL DIRECTOR NAME						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Joseph Gawler's Sons, Inc.						AUG 27 1981		Frances Jean Nathan			
5130 Wisc. Ave. N.W. Wash., D.C.											

BP



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Mr. J. H. Jones

Local

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 and 2 should be filed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

BP

DHMH - 16 50M 1/81
(VRA 15, 4)

Item 6 g558 8/14/81 gj

1- STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST WALTER REX LOWRY			2a. DATE OF DEATH MONTH DAY YEAR AUGUST 1, 1981		2b. HOUR 1:28 PM
3. SEX MALE	4. RACE CAU.	5. DATE OF BIRTH MONTH DAY YEAR SEPT. 11, 1911	6. AGE (IN YEARS LAST BIRTHDAY) 70 69 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MISSOURI	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.		
10. CITY OR TOWN OF DEATH BETHESDA	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NATIONAL NAVAL MEDICAL CENTER		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) U.S. NAVY	12b. KIND OF BUSINESS OR INDUSTRY GOVT.	
13a. STATE MD.		13b. CITY OR TOWN ANN ARUNDEL	13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13d. STREET ADDRESS 670 AMERICANA DR. APT-12	
14. FATHER'S NAME FIRST MIDDLE LAST LEO LOWRY		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST GEORGIA DEARING			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 1942-1964		17. INFORMANT ADDRESS MARIE LOWRY, 670 AMERICANA DR., ANNAPOLIS, MD.	
18. CAUSE OF DEATH. Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) RESPIRATORY / CARDIAC FAILURE DUE TO, OR AS A CONSEQUENCE OF (b) SEVERE CAD, COPD s/p CABG X6 DUE TO, OR AS A CONSEQUENCE OF (c) KIDNEY FAILURE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: NO					
19a. DATE OF OPERATION 15 July 81		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from JULY 13, 1981 to AUGUST 1, 1981 , that <input checked="" type="checkbox"/> (we) lost sight of the deceased on AUGUST 1, 1981 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) did not view the body after death.					
22b. SIGNATURE Carolyn J. Harrington M.D.		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED AUG. 2, 1981	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) CAROLYN J. HARRINGTON M.D.		22e. ADDRESS NAVAL HOSPITAL, BETHESDA, MD.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation	23b. DATE 8-3-81	23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory	23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria, Virginia		
24. FUNERAL HOME NAME ADDRESS IVES FUNERAL HOME, 2847 WILSON BLVD. ARLINGTON, VA		25a. DATE REC'D. BY REGISTRAR AUG 5 1981			
		25b. REGISTRAR'S SIGNATURE James E. Norton			

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8121722	
1. FOR STATE REGISTRAR		REG. NO.									
1. DECEASED NAME (TYPE OR PRINT)		FIRST SADIE		MIDDLE Mary		LAST LUDWIG		2a. DATE OF DEATH MONTH DAY YEAR 8-18-81		2b. HOUR 9:30 P	
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR April 8 1912		6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		7b. HOUR HRS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD					
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1803 Dennis Avenue				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Purchasing Agent		12b. KIND OF BUSINESS OR INDUSTRY G.S.A.			
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1803 Dennis Avenue			
14. FATHER'S NAME FIRST MIDDLE LAST Samuel Albert Fine		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Esther Phillips									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 578-12-8030		17. INFORMANT niece Sandra R. Huddelson		ADDRESS 13031 Victoria Hgts. Bowie, Md. 20715					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>immediate</u>	
4920 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: DUE TO, OR AS A CONSEQUENCE OF (b) <u>Severe pulmonary insufficiency</u>										> 10 yrs	
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Severe emphysema</u>										> 30 yrs	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): <u>Coronary Artery Disease</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>June 16, 1981</u> to <u>18 Aug 81</u> , that (I) (we) last saw the deceased alive on <u>11 Aug 81</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If (a) I did (I did not) view the body of the deceased.											
22b. SIGNATURE <u>Alan I. Kermaier, MD</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <u>19 Aug 81</u>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ALAN I. KERMAIER, MD		22e. ADDRESS 9801 GEORGIA AVE S.S., MD 20902									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Aug. 22, 1981		23c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Washington, D. C.					
24. FUNERAL DIRECTOR NAME Francis J. Collins		ADDRESS 500 University Blvd., W. Silver Spring, Md.				25a. DATE REC'D. BY REGISTRAR AUG 25 1981		25b. REGISTRAR'S SIGNATURE <u>Francis J. Collins</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										
CERTIFICATE OF DEATH										
REG. NO. 8121723										
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST CHARLES A. MACARTHUR					2a. DATE OF DEATH MONTH DAY YEAR 08 08 81					2b. HOUR 6:15 A.M.
3. SEX male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 09 19 93		6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS 00 00		7. IF UNDER 24 HRS. HOURS MIN. 00 00
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.				
10. CITY OR TOWN OF DEATH SILVER SPRING		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOLY CROSS HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Brick Layer		12b. KIND OF BUSINESS OR INDUSTRY Retired		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY Anne Arundel		13c. CITY OR TOWN Annapolis		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 206 D Victor Parkway		
14. FATHER'S NAME FIRST MIDDLE LAST Peter MacArthur					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Hannah Morrell					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 209-09-9145A		17. INFORMANT ADDRESS C. therine MacArthur (same as 13e)						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral pneumonia 5070 DUE TO, OR AS A CONSEQUENCE OF (b) Aspiration Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 weeks recurrent										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). congestive heart failure; chronic organic brain syndrome										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from 7/7/81 to 8/8/81 , that (I) (we) lost saw the deceased alive on 8/8/81 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did not view the body after death, so state.)										
22b. SIGNATURE Martin C. Sharf		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8/8/81				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MARTIN C. SHARFEL				22e. ADDRESS 3720 FARRAGUT AVE KENSINGTON, MD-20895						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 08-09-81		23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crema.		23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria, Arlington, Va.				
24. FUNERAL DIRECTOR NAME Beall Funeral Home, 1212 West St., Anna., Md.				25a. DATE REC'D. BY REGISTRAR REGISTRAR'S SIGNATURE AUG 11 1981						

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Baltimore City Health Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 1 2 1 7 2 4	
1. FOR STATE REGISTRAR			REG. NO.								
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR		
Gladys Lea MACDONALD						August 15 1981			4:00A M		
3 SEX		4 RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
Female		Caucasian		Nov. 29 1918		62 YRS					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Illinois		USA				Montgomery MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Bethesda		National Naval Medical Center						Housewife			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE			13b. CITY OR TOWN			13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13d. STREET ADDRESS		
Virginia			Norfolk						1846 East Littlecreek Road		
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST								
William Finney			Gertrude Fisher								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS			707		
Yes			1953-59			037 26 0648			William R. Crews 12630 Viers Mill Rd. Apt. /		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Small cell carcinoma of the lung</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
1629 } DUE TO, OR AS A CONSEQUENCE OF (b) _____											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c) _____											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I/ (this hospital) attended the deceased from <u>July 22</u> , 19 <u>81</u> , to <u>Aug. 15</u> , 19 <u>81</u> , that I/ (we) last saw the deceased alive on <u>Aug. 15</u> , 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If incorrect, did not view the body after death.)											
22b. PHYSICIAN'S NAME (TYPE OR PRINT)			22c. ADDRESS			22d. DATE SIGNED					
Joseph F. Hacker, III, M.D.			National Naval Medical Center Bethesda, Md.			Aug. 17 1981					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION CITY OR TOWN COUNTY STATE		
24. FUNERAL DIRECTOR NAME						25a. DATE REC'D. BY REGISTRAR					
Tyson Wheeler Funeral Home Rockville, Md.						AUG 20 1981					

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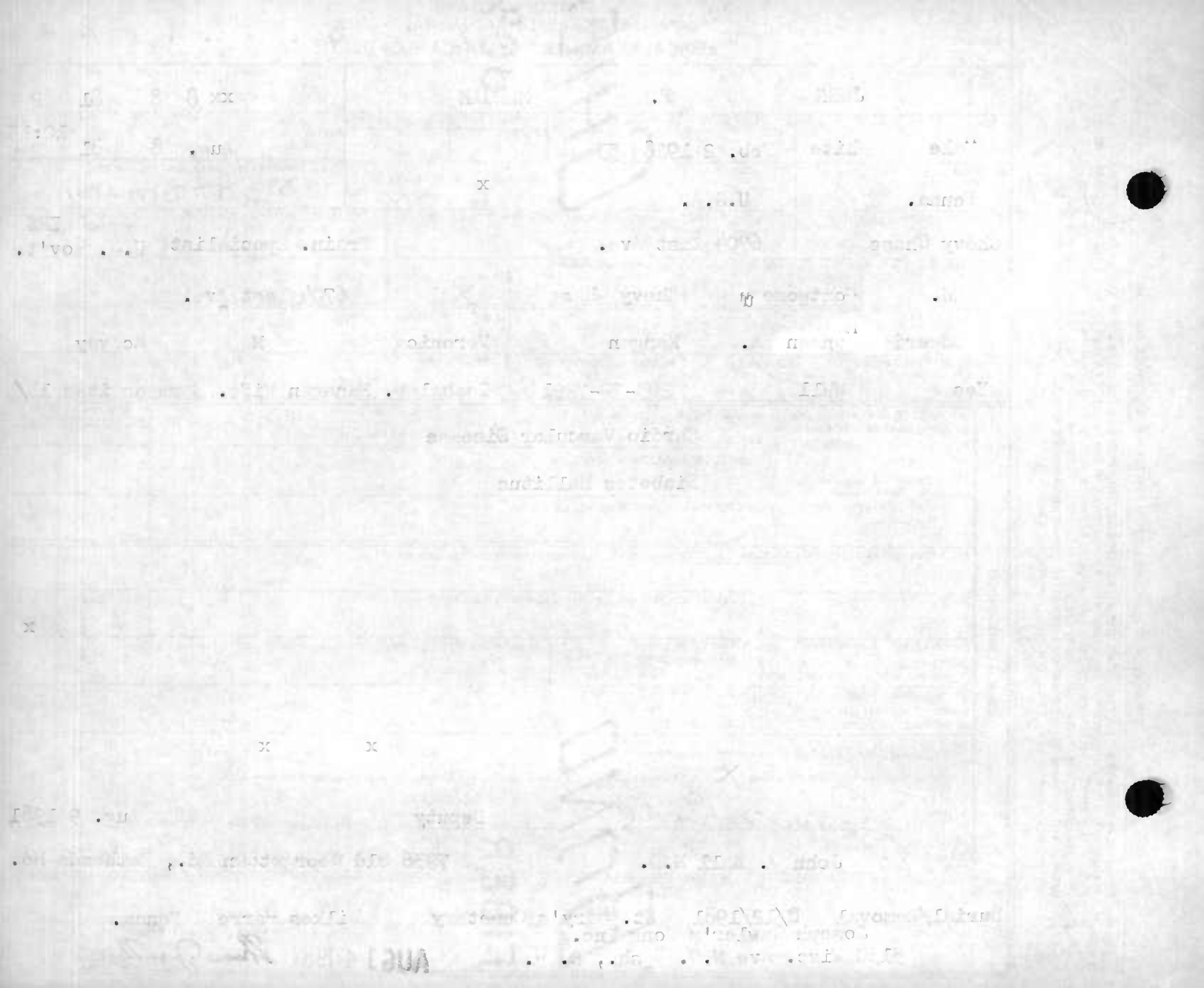
Handwritten signature and date: 10/10/10

Handwritten signature and date: 10/10/10

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 WITH YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 21725	
1- FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) JOHN F. MANGAN										2a. DATE KNOWN OF DEATH 8 8 1981	
3. SEX Male		4. RACE White		5. DATE OF BIRTH Feb. 2 1928		6. AGE (IN YEARS) 53		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penna.				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD	
10. CITY OR TOWN OF DEATH Chevy Chase				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 6704 East Ave.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Train. Specialist		12b. KIND OF BUSINESS OR INDUSTRY IRS U.S. Gov't.	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE Md.		13b. COUNTY Montgomery		13c. CITY OR TOWN Chevy Chase		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 6704 East Ave.			
14. FATHER'S NAME FIRST Edward MIDDLE A. LAST Mangan				15. MOTHER'S MAIDEN NAME FIRST Veronica MIDDLE M LAST McAvay							
16a. WAS DECEASED EVER (YES, NO, OR UNKNOWN) Yes		IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES) WWII		16b. SOCIAL SECURITY NO. 205-20-7291		17. INFORMANT ADDRESS Isabel P. Managan Wife. Same as item 13/					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 2500 Cardio Vascular Disease IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (b) Diabetes Mellitus DUE TO, OR AS A CONSEQUENCE OF (c) 										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE John G. Ball				TITLE (SPECIFY) Deputy				DATE SIGNED Aug. 9 1981			
EXAMINER'S NAME (TYPE OR PRINT) John G. Ball M.D.				ADDRESS 7936 Old Georgetown Rd., Bethesda Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial/Removal				23b. DATE 8/12/1981		23c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery		23d. LOCATION CITY OR TOWN Wilkes Barre COUNTY Penna. STATE			
24. FUNERAL DIRECTOR NAME Joseph Gawler's Sons Inc.				ADDRESS 5130 Wisc. Ave N.W. sh., D. C.				25a. DATE REC'D. BY REGISTRAR AUG 14 1981		25b. REGISTRAR'S SIGNATURE Anna J. [Signature]	

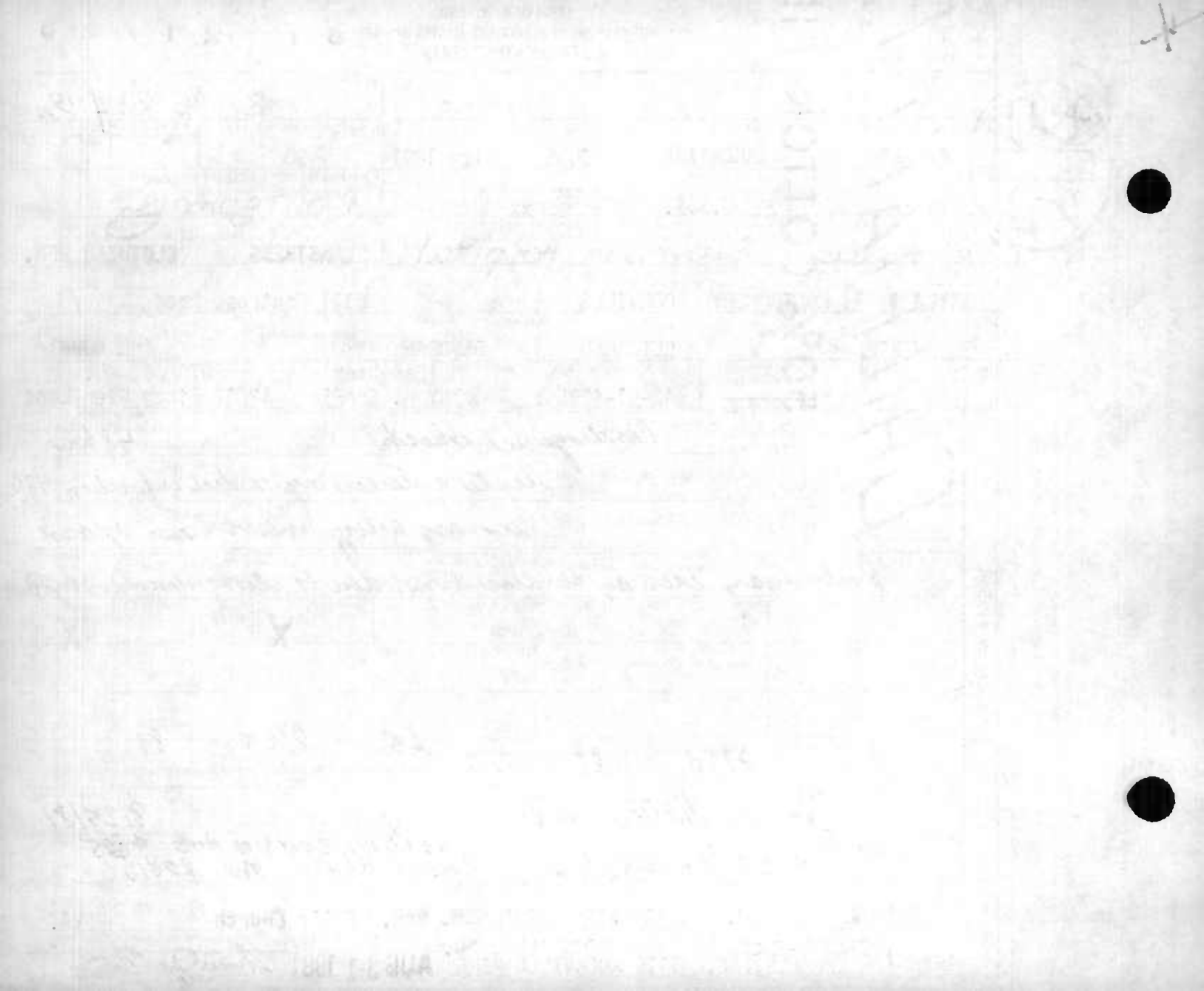


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified and file.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8 1 2 1 7 2 6	
1. FOR STATE REGISTRAR				CERTIFICATE OF DEATH						REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Esther</i> <i>Marcus</i>				2a. DATE OF DEATH MONTH DAY YEAR <i>8 25 81</i>				2b. HOUR <i>4:15 P.M.</i>			
3. SEX <i>FEMALE</i>		4. RACE <i>CAUCASIAN</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>JUNE 11, 1891</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>90</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 74 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>RUSSIA</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery</i> MD.					
10. CITY OR TOWN OF DEATH <i>Bethesda</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Suburban Hospital</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>SEAMSTRESS</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>CLOTHING MFR.</i>			
13a. STATE <i>MARYLAND</i>				13b. COUNTY <i>MONTGOMERY</i>		13c. CITY OR TOWN <i>ROCKVILLE</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <i>6111 Montrose Road</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>PHILIP</i> <i>GLICKMAN</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>DEVORAH</i> <i>(UNKNOWN)</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>NO</i>				16b. SOCIAL SECURITY NO. <i>542-01-4795</i>		17. INFORMANT (Daughter) ADDRESS <i>POTOMAC, MD.</i>		17b. ADDRESS <i>DOROTHY M. SHAPIRO 12012 Piney Glen Lane</i>			
18. CAUSE OF DEATH (Enter only one cause per line for 1a, b, and c.) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiogenic Shock</i> 4100 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Acute anterior myocardial infarction - 48 hrs.</i> (c) <i>Coronary artery atherosclerosis 4 years</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>48 hrs.</i>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. <i>Pulmonary edema, cardiac arrest due to idioventricular rhythm</i>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <i>65</i> to <i>8/25</i> 19 <i>81</i> , that (I) (we) lost <i>saw</i> the deceased alive on <i>8/25</i> 19 <i>81</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>T. James Waters, M.D.</i>				DEGREE <i>T. JAMES WATERS, M.D.</i>				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>8/25/81</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>T. JAMES WATERS, M.D.</i>				22e. ADDRESS <i>5530 WISCONSIN AVE #805 CHEVY CHASE, MD. 20815</i>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>				23b. DATE <i>AUG. 27, 81</i>		23c. NAME OF CEMETERY OR CREMATORY <i>KING DAVID MEM. GAR.</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Falls Church VA.</i>			
24. FUNERAL DIRECTOR NAME <i>DANZANSKY-GOLDBERG</i>				ADDRESS <i>ROCKVILLE, MD. 1170 ROCKVILLE PIKE</i>				25a. DATE REC'D. BY REGISTRAR <i>AUG 31 1981</i>		25b. REGISTRAR'S SIGNATURE <i>James J. Waters</i>	



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE EXAMINER SHOULD WRITE "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA 3. RETAIN PAGE 5 FOR THE FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

FOR STATE REGISTRAR										DEPARTMENT OF HEALTH AND MENTAL HYGIENE										MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 21727																																																																					
1. DECEASED NAME (TYPE OR PRINT)										2a. DATE KNOWN OF DEATH										2b. HOUR																																																																															
FIRST MARY										MIDDLE LOUISE										LAST MARTINELLI										2a. DATE KNOWN OF DEATH										2b. HOUR																																																											
3 SEX										4 RACE										5. DATE OF BIRTH										6. AGE (IN YEARS)										7. IF UNDER 1 YR.										8. IF UNDER 24 HRS.										9. BALTIMORE CITY OR COUNTY OF DEATH																																							
Female										White										Sep. 18, 1918										62 YRS.										MONTHS										DAYS										HOURS										MIN.										2c. DATE PRONOUNCED DEAD										2d. HOUR									
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)										7b. CITIZEN OF WHAT COUNTRY?										8. MARRIED										NEVER MARRIED										9. BALTIMORE CITY OR COUNTY OF DEATH										10. CITY OR TOWN OF DEATH										11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)										12b. KIND OF BUSINESS OR INDUSTRY																			
Wash. D.C.										USA										WIDOWED										DIVORCED										Montgomery County MD.										Takoma Park										6914 Prince Georges Avenue										Housewife																													
13a. STATE										13b. COUNTY										13c. CITY OR TOWN										13d. INSIDE CITY LIMITS?										13e. STREET ADDRESS																																																											
Md.										Mont.										Takoma Park										YES										NO										6914 Pr. George Avenue																																																	
14. FATHER'S NAME										15. MOTHER'S MAIDEN NAME										16a. WAS DECEASED EVER IN U.S. ARMED FORCES?										16b. SOCIAL SECURITY NO.										17. INFORMANT										ADDRESS										Same as above																																							
FIRST ALFIO										MIDDLE DiGregorio										LAST										FIRST ANGELA										MIDDLE Tomaselli										LAST										None										219 72 0034										Domenick Martinelli (Husband)																			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										19. IMMEDIATE CAUSE (a)										20. DUE TO, OR AS A CONSEQUENCE OF										21. YEARS																																																																					
PART I DEATH WAS CAUSED BY:										Acute myocardial disease										DUE TO, OR AS A CONSEQUENCE OF										Years																																																																					
4291										Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.										(b) chronic myocardial disease.										DUE TO, OR AS A CONSEQUENCE OF																																																																					
(c)																																																																																																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).										None																																																																																									
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY?																																																																															
None										None										YES										NO																																																																					
21a. EXTERNAL CAUSE WAS										21b. TIME OF INJURY										21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)																																																																															
UNDERLYING										OR CONTRIBUTING										CAUSE OF DEATH										P.M.										19										None																																																	
21d. INJURY OCCURRED										21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)										21f. LOCATION										CITY OR TOWN										COUNTY										STATE																																																	
WHILE AT WORK										NOT WHILE AT WORK																																																																																									
22a. I certify that I took charge of the remains described above, held an										Autopsy										Inspection										Inquiry										and in my opinion																																																											
death resulted from:										Natural causes										Accident										Suicide										Homicide										Undetermined manner																																																	
ACTUAL SIGNATURE										TITLE (SPECIFY)										DATE SIGNED																																																																															
John S. Rogers, M.D.										Deputy										8/14/81																																																																															
EXAMINER'S NAME										ADDRESS																																																																																									
John S. Rogers, M.D.										1919 Seminary Road										Silver Spring, Montgomery, Md.																																																																															
23a. BURIAL, CREMATION, REMOVAL										23b. DATE										23c. NAME OF CEMETERY OR CREMATORY										23d. LOCATION										CITY OR TOWN										COUNTY										STATE																																							
Burial										8/17/81										Gate of Heaven										Silver Spring										Mont.										Md.																																																	
24. FUNERAL DIRECTOR										NAME										ADDRESS										25a. REG. BY REGISTRAR										25b. SIGNATURE																																																											
Hines/Rinaldi										F.H. 11800										N.H. Ave, S.S. Md.										AUG 18 1981																																																																					

11/18/51



AUG 1 1951

Cleared by medical examiner

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filled within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 1 2 1 7 2 8	
1. FOR STATE REGISTRAR				CERTIFICATE OF DEATH	
I. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH MONTH DAY YEAR	
FIRST MIDDLE LAST Walter MASNOVO				Aug. 5, 1981	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR	
Male		White		Nov. 26, 1912	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		6. AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS	
Argentina		United States		68 yrs	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		9. BALTIMORE CITY OR COUNTY OF DEATH MD.	
Silver Spring		Holy Cross Hospital ER		Montgomery County	
12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		12b. KIND OF BUSINESS OR INDUSTRY		12c. STREET ADDRESS	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN	
Maryland		Montgomery		Kensington	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		16. SOCIAL SECURITY NO.	
Michael Masnov		Madeline Muller		100-07-6764	
17a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		17b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
Yes		WW II		son-in-law, Martin Ruttkay	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
4140 Cardiopulmonary arrest					10 years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) arterio sclerotic heart disease					
DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Hypertension					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 19 61 to Aug. 5 19 81, that (I) (we) last saw the deceased alive on June 19 19 81 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) visit the body after death.		22b. SIGNATURE DEGREE		22c. DATE SIGNED	
22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (TYPE OR PRINT)	
Wilfred R. Ehrmantraut M.D.		22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	
Wilfred R. Ehrmantraut		11125 Rockville Pike, Rockville Md		Burial	
23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
8-10-81		Hillcrest Cemetery		Louisiana Virginia	
24. FUNERAL DIRECTOR NAME ADDRESS		25. DATE OF DEATH		26. SIGNATURE	
Woodward Funeral Home, Louisa, Virginia		AUG 14 1981		26. SIGNATURE	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and 3 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

DHMH - 16 50M 1/B1
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8121729	
1. FOR STATE REGISTRAR		REG. NO.									
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH MONTH DAY YEAR				2b. HOUR			
MARGARET DOLE McCALL				AUGUST 9, 1981				6:00A M			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
FEMALE		CAUCASIAN		JAN 26, 1891		90 YRS					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
MASSACHUSETTS		U.S.A.				MONTGOMERY MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
WHEATON		RANDOLPH HILLS NURSING HOME				HOUSEWIFE					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
NEW YORK		BRONX		BRONX		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		525 WEST 238TH STREET			
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
NATHAN H. DOLE				HELEN BENNETT							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT		ADDRESS					
NO		129-38-0600		DAUGHTER MARGARET YULE		12857 KITCHEN HOUSE WAY GERMANTOWN, MARYLAND					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac ventricular arrhythmia</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>coronary arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>4140</u> Conditions, if any, which gave rise to: immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>instant</u> <u>years</u>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Chronic organic brain syndrome</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (this hospital) attended the deceased from <u>8/9</u> 19 <u>81</u> , to <u>8/9</u> 19 <u>81</u> , that <u>we</u> last saw the deceased alive on <u>8/9</u> 19 <u>81</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.		22b. SIGNATURE <u>Martin C. Shargel</u> DEGREE <u>M.D.</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>8/9/81</u>							
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS									
MARTIN C. SHARGEL M.D.		3726 FARRACUT AVE KENSINGTON MD - 20895									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
cremation		8/10/81		METROPOLITAN CREMATORY		ALEXANDRIA VIRGINIA					
24. FUNERAL DIRECTOR NAME						25. DATE REC'D BY REGISTRAR OR REGISTRAR'S SIGNATURE					
FRANCIS J. COLLINS 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901						AUG 12 1981 <u>Francis J. Collins</u>					

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or interment.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						8121730	
1. FOR STATE REGISTRAR						REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) Ralph Dennis McCurry, Sr.						2a. DATE OF DEATH MONTH DAY YEAR August 22, 1981	
3 SEX Male						2b. HOUR A M 6:54 A	
4 RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Nov. 30, 1914		6 AGE (IN YEARS LAST BIRTHDAY) 66 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Missouri		7b. CITIZEN OF WHAT COUNTRY? United States		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.	
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Clinical Center, NIH, Bethesda, Md.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Supervisor		12b. KIND OF BUSINESS OR INDUSTRY Consulting	
13a. STATE Missouri		13b. CITY OR TOWN Fairgrove		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS Rt. 1 65648	
14. FATHER'S NAME FIRST MIDDLE LAST Jacob McCurry				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nora Hill			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 494-18-3317		17 INFORMANT ADDRESS Mrs. Thelma McCurry (wife) same as patient			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Hemorrhagic pneumonitis - sepsis 0389 DUE TO, OR AS A CONSEQUENCE OF (b) Generalized infection including GI tract, lungs and prostate gland DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from August 21, 1981, to August 22, 1981, that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on August 22, 1981, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. (two) (did not) view the body after death.							
22b. SIGNATURE Mitchell S. Finkel, MD				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 8/22/81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Mitchell S. Finkel, MD				22e. ADDRESS National Institutes of Health Clinical Center, Bethesda, Md. 20205			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE August 26, 1981		23c. NAME OF CEMETERY OR CREMATORY Mt. Olive Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Fairgrove Green Missouri	
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Homes, P.A., Bethesda, Maryland				25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE AUG 26 1981 [Signature]			

BP

For the year 1951

1951-11-11

1951 3 8 30A

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified before burial or cremation.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
1- STATE REGISTRAR					8 1 2 1 7 3 1				
1. DECEASED NAME (TYPE OR PRINT)					REG. NO.				
MARY JOSEPHINE MC HUGH					2a. DATE OF DEATH MONTH DAY YEAR 8-11-81				
3. SEX Female					2b. HOUR 9:05 PM				
7. RACE Caucasian					6. AGE (IN YEARS LAST BIRTHDAY) 98 YRS.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Massachusetts					5. DATE OF BIRTH MONTH DAY YEAR August 4, 1883				
7b. CITIZEN OF WHAT COUNTRY? United States					8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				
10. CITY OR TOWN OF DEATH BETHESDA					9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery				
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SUBURBAN HOSPITAL					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife				
12b. KIND OF BUSINESS OR INDUSTRY Home									
13a. STATE Maryland					13b. COUNTY Montgomery				
13c. CITY OR TOWN Bethesda					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
14. FATHER'S NAME FIRST MIDDLE LAST Peter Morlock					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emilie Root				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No					16b. SOCIAL SECURITY NO. 215-48-4253				
17. INFORMANT Mary J. Corridon					ADDRESS Same as 13				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CONGESTIVE HEART FAILURE</u> 4920 DUE TO, OR AS A CONSEQUENCE OF, <u>CHRONIC OBST. RESP. DIS</u> DUE TO, OR AS A CONSEQUENCE OF, <u>EMPHYSEMA</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 DAYS</u> <u>YEARS</u> <u>YEARS</u>									
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>SEMI-CONSCIOUS</u>									
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)					21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK					21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				
21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (we) attended the deceased from <u>8/11/81</u> to <u>8/11/81</u> , that (I) (we) last saw the deceased alive on <u>8/11/81</u> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE THOS. G. WARD, MD					22c. DATE SIGNED 8/12/81				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) THOS. G. WARD, 6116 ROBIN WOOD, BETHESDA, MD 20817					22e. ADDRESS				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial					23b. DATE August 14, 1981				
23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven					23d. LOCATION CITY OR TOWN COUNTY Silver Spring, Maryland				
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Homes, P.A. Bethesda, Maryland					25a. DATE REC'D. BY REGISTRAR AUG 18 1981				
25b. REGISTRAR'S SIGNATURE [Signature]									

COMPETITIVE HEART FAILURE - 1 DAY
 CHRONIC DYST. R.A.D. 1.2
 YEARS
 2 MONTHS 2 WEEKS
 2 MONTHS

Those WARD, will remain used, 11/1/81
 11/1/81
 11/1/81

AUGUST 1981
 11/1/81
 11/1/81

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 2 1 / 3 2

1. FOR STATE REGISTRAR		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <i>Helen McIntosh</i>		2a. DATE OF DEATH MONTH DAY YEAR <i>8/19/81</i>	
3. SEX <i>Female</i>		2b. HOUR <i>1630</i>	
4. RACE <i>White</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>86</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Ohio</i>		8. MARried <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery</i> MD.	
10. CITY OR TOWN OF DEATH <i>Gaithersburg</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>H.M. Wilson Health Care Center</i>	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Homemaker</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>N/A</i>	
13a. STATE <i>Maryland</i>		13b. COUNTY <i>Montgomery</i>	
13c. CITY OR TOWN <i>Gaithersburg</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS <i>403 Russell Ave, Apt # 613</i>		14. FATHER'S NAME FIRST MIDDLE LAST <i>William McMillian</i>	
15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Etta Jamieson</i>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>	
16b. SOCIAL SECURITY NO. <i>578-62-5733</i>		17. INFORMANT ADDRESS <i>Samuel W. McIntosh /Husband/ same as 13e</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>METASTATIC CA, LUNGS & BRAIN</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>3 months</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		(b) <i>CAARCINOMA, LUNG</i>	
		(c) <i>2 years</i>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>None</i>			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>June 8/19/81</i>	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>June 8/19/81</i> to <i>8/19/81</i> , that (I) (we) lost <i>the deceased alive on 8/19/81</i> <i>above, (I) (we) (did) (did not) view the body after death</i>			
22b. SIGNATURE <i>Thos G. Ward</i>		22c. DATE SIGNED <i>8/19/81</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Thos G. Ward, 6116 Robinwood, Bethesda, MD 20817</i>		22e. ADDRESS <i>Lee's Crematory, Washington D.C.</i>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Cremation</i>		23b. DATE <i>8-20-81</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Lee's Crematory</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Washington D.C.</i>	
24. FUNERAL DIRECTOR <i>Hines/Rinaldi Funeral Home</i>		25a. DATE REC'D. BY REGISTRAR <i>AUG 21 1981</i>	
25b. SIGNATURE <i>Thos G. Ward</i>			

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death. WITH THE STATE DEPT. OF HEALTH AND MENTAL HYGIENE PRIOR TO BURIAL, CREMATION, OR REMOVAL.



2.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

RELEASED BY DR JOHN BALL DEPUTY M.E.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
1. FOR STATE REGISTRAR					8 1 2 1 7 3 3				
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH				
Maggie I. McKenney					8/11/81 0625				
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7b. HOUR	
Female		White		JUNE 4, 1882		99 YRS.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
VIRGINIA		U.S.A.				MONTGOMERY MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (DO NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
BETHESDA		SUBURBAN HOSPITAL		MACHINIST OPERATOR		STONE STRAW CO.			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
MARYLAND		MONTGOMERY		SILVER SPRING		YES XX NO <input type="checkbox"/>		1403 DILSTON ROAD	
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME				
ROBERT V. SUTTON					THEODOSIA HARRISON				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)					16b. SOCIAL SECURITY NO.				
NO					577-09-6896				
17. INFORMANT					ADDRESS				
EARL V. McKENNEY					SAME AS 13 SON				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART I. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) Hemorrhage									
DUE TO, OR AS A CONSEQUENCE OF (b) Hematuria									
DUE TO, OR AS A CONSEQUENCE OF (c) CA, URINARY BLADDER									
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
1889 2 DAYS									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:									
SEMI-LETT									
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR				
					19 P.M.				
21a. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>					21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				
					21c. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (1) (the hospital) attended the deceased from May 81, 1981, to 8/11/81, that (1) (we) last saw the deceased alive on 8/11/81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated									
22b. SIGNATURE									
THOS G. INARD, MD									
22c. DATE SIGNED									
8/11/81									
22d. PHYSICIAN'S NAME (TYPE OR PRINT)									
THOS G. INARD, MD									
22e. ADDRESS									
6116 ROBINWOOD, BETHESDA, MD									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)					23b. DATE				
BURIAL					8/14/81				
23c. NAME OF CEMETERY OR CREMATORY					23d. LOCATION CITY OR TOWN COUNTY STATE				
CEDAR HILL CEMETERY					SUITLAND PRI GEO MD.				
24. FUNERAL DIRECTOR					25a. DATE REC'D. BY REGISTRAR				
FRANCIS J. COLLINS					AUG 12 1981				
500 UNIV. BLVD., W., SILVER SPRING, MD. 20901					25b. REGISTRAR'S SIGNATURE				
					Francis J. Collins				

REVIEWED BY THE JCHM BUT DELIVERED BY THE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 1 2 1 7 3 4	
1- FOR STATE REGISTRAR		REG. NO.									
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH			MONTH DAY YEAR		2b. HOUR	
Aubrey Lee Meadows					August 23, 1981					10:30 A.	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
Male		White		February 11, 1922		59		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
West Virginia		USA				Montgomery County MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)									
Bethesda		Clinical Center, NIH, Bethesda, Md.									
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY									
N/A											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS		25801	
West Va.		Kaleigh		Beckley		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		318 Lincoln St.			
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME						
James Garfield Meadows					Janie Sims						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS				
Yes					236-22-7031		Mrs. Eunice Meadows (wife) same as patient				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>PNEUMONIA</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
2041 } DUE TO, OR AS A CONSEQUENCE OF (b) <u>ACUTE MYELOGENOUS LEUKEMIA</u>										2 WEEKS	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c) <u>CHRONIC LYMPHOCYTIC LEUKEMIA</u>										7 MONTHS	
										10 YEARS	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>NONE</u>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
NONE								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
				HOUR A.M. MONTH DAY YEAR							
21d. INJURY OCCURRED				21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION					
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>						CITY OR TOWN COUNTY STATE					
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>July 15</u> , 19 <u>81</u> , to <u>August 23</u> , 19 <u>81</u> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <u>August 23</u> , 19 <u>81</u> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above <input checked="" type="checkbox"/> (we) did <input type="checkbox"/> (we) did not view the body after death.											
22b. SIGNATURE						DEGREE			22c. DATE SIGNED		
Jeffrey W. Clark, M.D.						ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			August 24, 1981		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS					
JEFFREY W. CLARK						National Institutes of Health Clinical Center, Bethesda, Md. 20205					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION			
Burial			8-28-81		Blue Ridge Mem. Gard.			Beckley COUNTY W. Va. STATE			
24. FUNERAL DIRECTOR						25a. DATE REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
Melton Mortuary						SEP 8 1981			Ronald Jan Nathan		

BP.

APU 21 July 1964

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James Earl Ray

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1. The first step is to identify the problem or question that needs to be answered. This involves understanding the context and the specific requirements of the task.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or entombment.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <u>Albert Samuel Metz</u>					2a. DATE OF DEATH MONTH DAY YEAR <u>8-20-81</u>			2b. HOUR <u>11:40</u> P. M.	
3. SEX <u>MALE</u>		4. RACE <u>WHITE</u>		5. DATE OF BIRTH MONTH DAY YEAR <u>DEC 18 1895</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>85</u> YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>PENNA</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>MONTGOMERY</u> MD.			
10. CITY OR TOWN OF DEATH <u>TAKOMA PARK</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>WASHINGTON ADVENTIST HOSPITAL</u>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>FED. GOVT.</u>		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <u>MD.</u> 13b. COUNTY <u>PR GEO</u> 13c. CITY OR TOWN <u>TAKOMA PARK</u>					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <u>517 ELM AVENUE</u>		
14. FATHER'S NAME FIRST MIDDLE LAST <u>AUGUST METZ</u>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>AMELIA</u>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>YES</u>		16b. SOCIAL SECURITY NO. <u>NNI</u>		17. INFORMANT ADDRESS <u>MARY M. MCCOY - 1106 LINDEN AVE T.P.</u>					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Sepsis from Aspiration pneumonia</u> 5070 } DUE TO, OR AS A CONSEQUENCE OF (b) <u>Organic brain disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>P.M. 19</u>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>5/25</u> 19 <u>81</u> , to <u>8/20</u> 19 <u>81</u> , that (I) (we) lost saw the deceased alive on <u>8/20</u> 19 <u>81</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.									
22b. SIGNATURE <u>[Signature]</u> DEGREE _____					ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <u>8/21/81</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>SMITH & HO M.D.</u>					22e. ADDRESS <u>8323 Haddon DR. Takoma Park Md.</u>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>Aug 25 1981</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Walnut Hill Cemetery</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Farmers Branch Penn</u>			
24. FUNERAL DIRECTOR NAME ADDRESS <u>Takoma Funeral Home - 254 Carroll Ave. N.W. - Wash. DC</u>					25a. RECEIVED BY REGISTRAR <u>AUG 25 1981</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		

The first of these is the fact that the
 system is not a simple one. It is a
 complex one, and it is not possible to
 describe it in a few words. It is a
 system of many parts, and it is not
 possible to describe it in a few words.

The second of these is the fact that the
 system is not a simple one. It is a
 complex one, and it is not possible to
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 system of many parts, and it is not
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 describe it in a few words. It is a
 system of many parts, and it is not
 possible to describe it in a few words.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 1 2 1 / 3 6
CERTIFICATE OF DEATH

1. FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Melvin Lloyd Miller			2a. DATE OF DEATH MONTH DAY YEAR 8-29-81			2b. HOUR 11:35 AM			
3. SEX male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 4 23 1923		6. AGE (IN YEARS (LAST BIRTHDAY)) 58		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.			
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Estimator - Fairfax Tile		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Potomac		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 11409 Falls Road	
14. FATHER'S NAME FIRST MIDDLE LAST Branson E. Miller				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Jane Seaton					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes		16b. SOCIAL SECURITY NO. WW 11 217 16 0168		17. INFORMANT ADDRESS Fairfax, Va. Stephen Miller 3032 Cedar Lane					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Squamous cell carcinoma, esophagus 1509 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2+ yrs.	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) #1a metastatic to lungs, nodes, recurrent esophagus									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) this hospital attended the deceased from Aug. 28 19 81 and that in my (our) opinion death occurred on the date and hour and from the causes stated above (1) we did (1) we did not view the body after death.									
22b. SIGNATURE G. Bowditch Hunter, Jr. MD				DEGREE MD				22c. DATE SIGNED Aug. 29, 1981	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) G. Bowditch Hunter, Jr.				22e. ADDRESS 50 W. Edmonstone Drive, Rockville, MD, 20852					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9/1/81		23c. NAME OF CEMETERY OR CREMATORY St. Gabriel's Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Potomac, Maryland			
24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home, Inc. 1331 Rockville Pike Rockville, Maryland				25a. DATE REC'D. BY REGISTRAR SEP 01 1981		25b. REGISTRAR'S SIGNATURE James J. Nanthos			

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MEDICAL CERTIFICATION

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours of filing with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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Item #18 Film G559 9/14/81 rc

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 1 2 1 7 3 7

1- STATE
REGISTRAR

CERTIFICATE OF DEATH

REG. NO.

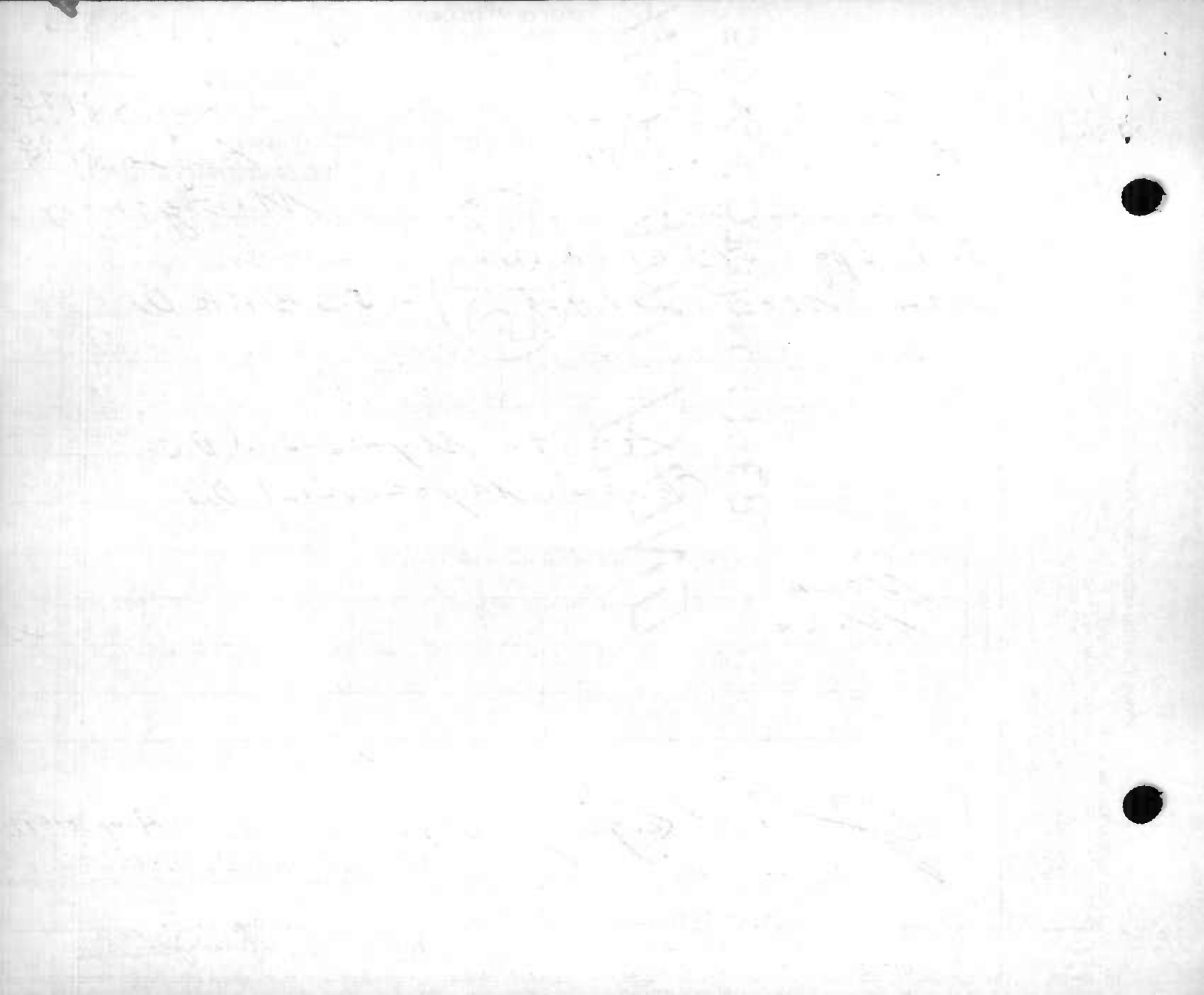
1 DECEASED NAME (TYPE OR PRINT) MEYER		FIRST MI MIDDLE LL LAST HER		2a. DATE OF DEATH MONTH 8 DAY 23 YEAR 81		2b. HOUR 0345	
3 SEX MALE		4 RACE White		5. DATE OF BIRTH MONTH Dec. DAY 28 YEAR 1897		6 AGE (IN YEARS LAST BIRTHDAY) 83	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Russia		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10 CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fairland Nursing & Retirement Ctr.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Owner		12b. KIND OF BUSINESS OR INDUSTRY Grocer-Liquor	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS 9039 Sligo Creek Pkwy., #602		14 FATHER'S NAME FIRST Philip MIDDLE Miller LAST Miller		15. MOTHER'S MAIDEN NAME FIRST Adel MIDDLE Unknown LAST Unknown			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 214-03-8539		17 INFORMANT Philip Miller		17b. ADDRESS 815 Lowander Lane Silver Spring, Maryland	
18 CAUSE OF DEATH (Enter only one cause per line for a, b, and c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1579 METASTATIC Carcinoma 8 mos. 1981 DUE TO, OR AS A CONSEQUENCE OF Carcinoma, pancreas & liver 1 year (b) CA LIVER 2-11 DUE TO, OR AS A CONSEQUENCE OF --- (c) --- APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH June DAY 8 YEAR 1981		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY ENTER IN PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) I (the hospital) attended the deceased from 8/19/81 to 8/23/81 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (or (was) (were) (did not) view the body after death).							
22b. SIGNATURE Thos G. Ward		22c. ADDRESS Beth Shalom Congregation		22d. DATE SIGNED 8/23/81			
22e. PHYSICIAN'S NAME (TYPE OR PRINT) Thos G. Ward M.D.		22f. ADDRESS Beth Shalom Congregation		22g. DATE SIGNED 8/23/81			
23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE 8/24/1981		23c. NAME OF CEMETERY OR CREMATORY Beth Shalom Congregation		23d. LOCATION Hillside, Maryland	
24 FUNERAL DIRECTOR NAME Donald M. Stein		24b. ADDRESS Hebrew Memorial F.H.		25a. DATE REC'D. BY REGISTRAR AUG 26 1981		25b. REGISTRAR'S SIGNATURE James J. ...	
24c. ADDRESS 232 Carroll Street, N. W. Washington, D. C.							

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 2 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 21738	
1. DECEASED NAME (TYPE OR PRINT) Caroline Emma Mills										2a. DATE KNOWN OF DEATH Aug 20 1981	
3. SEX Female		4. RACE White		5. DATE OF BIRTH Oct. 16 1998		6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		2b. DATE PRONOUNCED DEAD Aug 20 1981	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D. C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.					
10. CITY OR TOWN OF DEATH Pit. Spg		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 513 Blick Dr.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE MD		13b. COUNTY Mont.		13c. CITY OR TOWN Pit. Spg		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 513 Blick Dr			
14. FATHER'S NAME FIRST Bernard MIDDLE Fabian LAST Joy		15. MOTHER'S MAIDEN NAME FIRST Harriet MIDDLE P. LAST Ward		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 216-60-3423		17. INFORMANT Daughter ADDRESS Caroline J. Mills same as 13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Dist Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) Chronic Myocardial Dist DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) None											
19a. DATE OF OPERATION None		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE John S. Rogers		TITLE (SPECIFY) M.D.		MEDICAL EXAMINER				DATE SIGNED Aug 20 1981			
EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers, M.D.		ADDRESS 1919 Seminary Road, Silver Spring, Md									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Aug. 24, 1981		23c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery		23d. LOCATION CITY OR TOWN Washington, D. C. COUNTY STATE					
24. FUNERAL DIRECTOR NAME Francis J. Collins		ADDRESS 500 University Blvd., W. Silver Spring, Md.		25a. DATE RECD. BY REGISTRAR AUG 25 1981		REGISTRAR'S SIGNATURE Thomas J. Rogers					

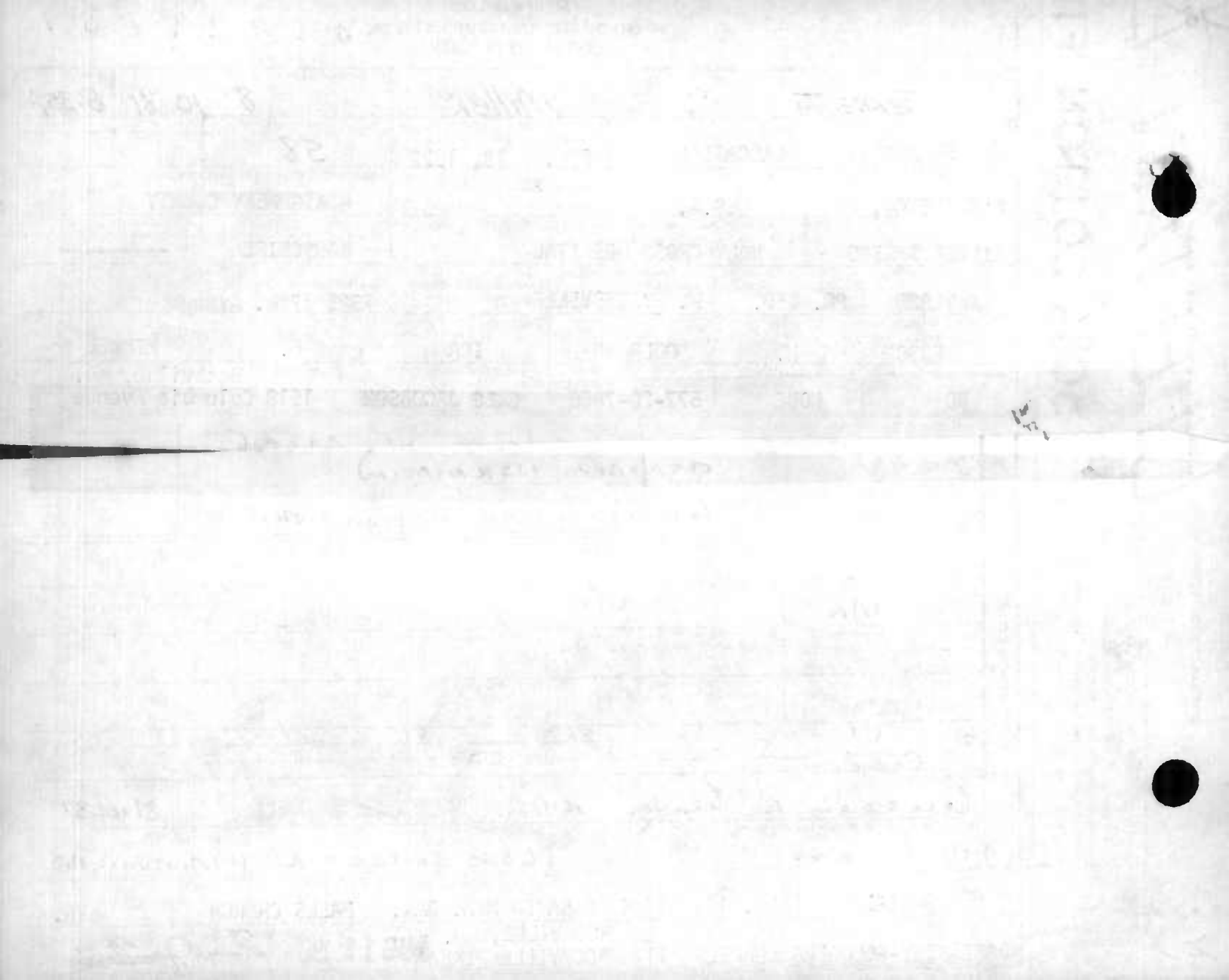


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove 10 pages. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation or inhumation.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic, the medical examiner must be notified at once.

1. FOR STATE REGISTRAR				DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 1 2 1 7 3 9			
CERTIFICATE OF DEATH				REG. NO.							
1. DECEASED NAME (TYPE OR PRINT) JEANETTE G. MILLER				2a. DATE OF DEATH MONTH 8 DAY 10 YEAR 81				2b. HOUR 6:35 PM			
3. SEX FEMALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH FEB. DAY 18. YEAR 1923		6. AGE (IN YEARS LAST BIRTHDAY) 58 YRS.		6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR MONTHS DAYS 		6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 72 HRS. HOURS MIN. 	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASHINGTON, DC		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD.					
10. CITY OR TOWN OF DEATH SILVER SPRING		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOLY CROSS HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY -----			
13a. STATE MARYLAND				13b. COUNTY PR. GEO.		13c. CITY OR TOWN W. HYATTSVILLE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 7325 17th. Avenue	
14. FATHER'S NAME FIRST BENSON MIDDLE H. LAST GOLDMAN				15. MOTHER'S MAIDEN NAME FIRST IDA MIDDLE E. LAST MINDL				16. ADDRESS Rockville, MD. 1518 Columbia Avenue			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 577-20-7866		17. INFORMANT GREG JACOBSON							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 4310 CARDIO-RESPIRATORY ARREST Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: CEREBRAL HERNIATION DUE TO, OR AS A CONSEQUENCE OF INTRACEREBRAL HEMORRHAGE											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 											
19a. DATE OF OPERATION N/A				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED N/A				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 19		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 					
22a. I certify that (1) (this hospital) attended the deceased from 8/10 19 81 to 8/10 19 81 that (1) (we) last saw the deceased alive on 8/10 19 81 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death, so state.)											
22b. SIGNATURE W. R. LEAHY				DEGREE MD				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8/10/81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) W. R. LEAHY				22e. ADDRESS 6525 BELCROFT RD. HYATTSVILLE, MD							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE AUG. 11, 81		23c. NAME OF CEMETERY OR CREMATORY KING DAVID MEM. GAR.		23d. LOCATION CITY OR TOWN FALLS CHURCH COUNTY VA. STATE VA.					
24. FUNERAL DIRECTOR NAME DANZANSKY-GOLDBERG CHAPELS ADDRESS ROCKVILLE, MD 1170 ROCKVILLE PIKE				25a. DATE REC'D. BY REGISTRAR AUG 13 1981		25b. REGISTRAR'S SIGNATURE James J. [Signature]					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR			REG. NO.						
1. DECEASED NAME (TYPE OR PRINT) Percy S. Milstead					2a. DATE OF DEATH MONTH DAY YEAR August 19, 1981			2b. HOUR M	
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR June 19, 1903		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hosp.				12a. OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Packing & Crating		12b. KIND OF BUSINESS OR INDUSTRY U.S. Government	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE Maryland					13c. CITY OR TOWN Prince Geo. Riverdale		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME Frank					15. MOTHER'S MAIDEN NAME Mary Strobert				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 578 01 6195		17. INFORMANT ADDRESS Mary M. Milstead Same as #13 (Wife)					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of colon</u> 1539 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 year
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (the hospital) attended the deceased from <u>July 14, 1981</u> to <u>Aug 19, 1981</u> , that (I) (we) last saw the deceased alive on <u>Aug 12, 1981</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (we) (did not) view the body after death.									
22b. SIGNATURE Walter E. Goetz MD						22c. DATE SIGNED 20 Aug 81		22d. PHYSICIAN'S NAME (TYPE OR PRINT) WALTER E. GOOZH MD	
23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE 8/21/81		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood P.G. Maryland			
24a. FUNERAL DIRECTOR NAME Frank Gasch's Funeral Home, P.A. Hyattsville, Maryland						25a. DATE REC'D. BY REGISTRAR AUG 24 1981		25b. REGISTRAR'S SIGNATURE Name	

MEDICAL CERTIFICATION



August 12, 1951

Alfred

1951

Washington Monument	USA	Washington Monument
Washington Monument	USA	Washington Monument
Washington Monument	USA	Washington Monument
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Washington Monument



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by page 3.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 1 2 1 / 4 2			
1. FOR STATE REGISTRAR				CERTIFICATE OF DEATH			
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH			
Elsie I. Moore				Aug 18 81 2 a m			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	
Female		Caucasian		September 5, 1901		79 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Maryland		United States				Montgomery MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Rockville		90 Monroe Street		Sales		Dress Shop	
13a. STATE				13b. COUNTY		13c. CITY OR TOWN	
Maryland				Montgomery		Rockville	
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME			
John H. Carey				Mary Bean			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
no				578-03-7924		Gladys C. Penn 626 Lincoln St., Rockville, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
IMMEDIATE CAUSE (a) 4416				10 yrs			
DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerosis				20 yrs			
DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):							
Recent treatment for hypertension							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		19c. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
		HOUR A.M. MONTH DAY YEAR					
		P.M. 19					
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION			
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from above, (I/we) (did) (did not) view the body after death.				22c. DATE SIGNED			
22b. SIGNATURE				DEGREE			
James T. Moore MD				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			
Paul T. Moore MD				5020 Edmonson Dr. B. Rockville			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION	
Burial		August 21, 1981		Washington Natl. Cemetery		SUITLAND COUNTY Maryland	
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR			
Robert A. Pumphrey 300 W. Montgomery Ave., Rockville, Maryland				Aug 28 1981			
				25b. REGISTRAR'S SIGNATURE			
				James Van Natten			



1. [Illegible text]
2. [Illegible text]
3. [Illegible text]
4. [Illegible text]
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16. [Illegible text]
17. [Illegible text]
18. [Illegible text]
19. [Illegible text]
20. [Illegible text]

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE MEDICAL EXAMINER SHOULD EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR THE FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 48 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 21743	
1. DECEASED NAME (TYPE OR PRINT) JAMES CHARLES MOORE						2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> 8-22-81		2b. HOUR 19		2c. DATE PRONOUNCED DEAD 8-22-81	
3. SEX male		4. RACE white		5. DATE OF BIRTH 12 15 '45		6. AGE (IN YEARS) 35 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD 8-22-81	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County					
10. CITY OR TOWN OF DEATH Olney		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery Co. General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Truck Driver		12b. KIND OF BUSINESS OR INDUSTRY Excavating			
13a. STATE Md.		13b. COUNTY Montgomery		13c. CITY OR TOWN Gaithersburg		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET ADDRESS 501B So. Frederick Ave., Apt. 1			
14. FATHER'S NAME Victor James Moore				15. MOTHER'S MAIDEN NAME Vivian Irene Fitts				16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No (IF YES, GIVE WAR OR DATES) -			
16b. SOCIAL SECURITY NO. 213-46-5349				17. INFORMANT Joan Eliz. Moore				17b. ADDRESS 501B So. Fred. Ave. #1 Gaithersburg, Md. 20877			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: Cranio-cerebral injury IMMEDIATE CAUSE (a) 8147 (b) (c) Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? 20. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY 7:40PM 8-22-81		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) pedestrian struck by auto							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) phone booth		21f. LOCATION Norwood & Layhill Rd. Silver Springs, Maryland							
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Margarita A. KOrrell				TITLE (SPECIFY) M.D. Assistant				DATE SIGNED 8-23-81			
EXAMINER'S NAME (TYPE OR PRINT) Margarita A. KOrrell, M.D.				ADDRESS 111 Penn Street							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/26/'81		23c. NAME OF CEMETERY OR CREMATORY Boys Presby. Church Cem.				23d. LOCATION Boys Montgomery Md.			
24. FUNERAL DIRECTOR Gartner Sandison F.H.				316 E. Diamond Ave., Gaithersburg, Md. 20877				25a. DATE REC'D. BY REGISTRAR AUG 27 1981		25b. REGISTRAR'S SIGNATURE [Signature]	

4



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Registrar after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8121744			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <i>Sarah</i>		FIRST MIDDLE LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
3 SEX <i>Female</i>		4 RACE <i>WHITE</i>		5 DATE OF BIRTH MONTH DAY YEAR		6 AGE (IN YEARS LAST BIRTHDAY)	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>NEW YORK</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery</i> MD.	
10 CITY OR TOWN OF DEATH <i>Rockville</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>POTOMAC VALLEY NURSING HOME</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Book-keeper</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Private</i>	
13a. STATE <i>Maryland</i>		13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Rockville</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Sam Cohen</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Sophie Beckerman</i>		16a. WAS DECEASED EVER IN U. S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. <i>078-26-3613</i>	
17. INFORMANT ADDRESS <i>Same as No. 13</i>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Renal Failure</i> <i>0384</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>pneumonitis (bilateral)</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>GRAM Negative Sepsis</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>12 HR.</i> <i>36 HR.</i> <i>36 HR.</i>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>12 hr. intermittent</i>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <i>19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <i>1-49</i> , 19 <i>81</i> , to <i>8-22</i> , 19 <i>81</i> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <i>August 22</i> , 19 <i>81</i> , and that in <input checked="" type="checkbox"/> (my) <input type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) <input type="checkbox"/> (did) view the body after death.							
22b. SIGNATURE <i>Frank J. Mayo</i>		DEGREE <i>M.D.</i> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>8-22-81</i>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Frank J. Mayo, M.D.</i>		22e. ADDRESS <i>6220 Frederick Rd. Gaithersburg, Md. 20860</i>					
23a. BURIAL, CREMATION, REMOVAL <i>Burial</i>		23b. DATE <i>8/24/1981</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Judean Memorial Garden</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Olney Montgomery Maryland</i>	
24. FUNERAL DIRECTOR <i>Donald M. Stein</i>		24b. ADDRESS <i>232 Carroll Street, N. W. Washington, D. C.</i>		25. DATE REC'D BY REGISTRAR <i>AUG 26 1981</i>		26. REGISTRAR'S SIGNATURE <i>Frank J. Mayo</i>	

[Faint, illegible text covering the majority of the page, likely bleed-through from the reverse side.]

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITH YOUR COPIES AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 21745	
1. DECEASED NAME (TYPE OR PRINT) Robert L. Morrissey						2a. DATE KNOWN OF DEATH ESTIMATED 8-12-1981		2b. HOUR 11:45 AM			
3. SEX Male	4. RACE Cauc.	5. DATE OF BIRTH MONTH DAY YEAR Aug. 3, 1919	6. AGE (IN YEARS) LAST BIRTHDAY 62 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD Aug 12 1981		2d. HOUR 11:45 AM			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Connecticut		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.					
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (# STREET ADDRESS) SUBURBAN hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Broker		12b. KIND OF BUSINESS OR INDUSTRY Food			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Bethesda		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 7807 English Way			
14. FATHER'S NAME FIRST MIDDLE LAST Michael J. Morrissey						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ann Lambert					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. WW II 046-09-1068		17. INFORMANT ADDRESS Regina C. Morrissey, Wife, Same as 13						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio Vascular Disease 4292 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE John S. Ball			TITLE (SPECIFY) M.D. Deputy			MEDICAL EXAMINER		DATE SIGNED Aug 12, 1981			
EXAMINER'S NAME (TYPE OR PRINT) John G. Ball, M.D.			ADDRESS 7936 Old Georgetown Road Bethesda, Maryland 20814								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE August 15, 1981		23c. NAME OF CEMETERY OR CREMATORY St. Gabriel's Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Potomac, Maryland				
24. FUNERAL DIRECTOR NAME ADDRESS Robert A. Pumphrey Funeral Homes, P.A. Bethesda, Maryland						25a. DATE REC'D. BY REGISTRAR AUG 18 1981		25b. REGISTRAR'S SIGNATURE Thane Jan Norton			



RECEIVED

SUBURBAN

LOCAL

STATION

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AND HON. CHIEF OF POLICE

RECEIVED

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CHIEF OF POLICE



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1900-1901

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of one.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8121746	
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		FIRST EVA	MIDDLE H.	LAST MOTLEY	2a. DATE OF DEATH MONTH DAY YEAR 8-7-81		2b. HOUR 2:54 AM		
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR March 12, 1880		6. AGE (IN YEARS LAST BIRTHDAY) 101		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY					
10. CITY OR TOWN OF DEATH TAKOMA PARK		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION WASHINGTON ADVENTIST HOSPITAL				12a. USUAL OCCUPATION (OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY OWN HOME			
13a. STATE Maryland		13b. COUNTY Prince Geo.		13c. CITY OR TOWN Hyattsville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 7005 23rd Avenue			
14. FATHER'S NAME LEVIN		MIDDLE HASTINGS		15. MOTHER'S MAIDEN NAME CAROLINE		MIDDLE HOLLAWAY		15. MOTHER'S MAIDEN NAME HOLLAWAY			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 578 10 8437		17. INFORMANT Edith M. Purvis		ADDRESS Same as #13		17. INFORMANT (Daughter)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CVA 4360 DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 Days	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 8/6/81 to 8/7/81 , that (I) (we) lost saw the deceased alive on 8/6/81 and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) did (did not) view the body after death.											
22b. SIGNATURE David K. Cromwell		DEGREE M.D.		22c. DATE SIGNED 8/7/81				22d. PHYSICIAN'S NAME (TYPE OR PRINT) David K. Cromwell, M.D.			
22e. ADDRESS 831 University Bl'vd E. Silver Spring, Md.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/10/81		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland P.G. Maryland					
24. FRANCIS GASCH'S SONS FUNERAL HOME, P.A. NAME Hyattsville, Maryland						25a. DATE REC'D. BY REGISTRAR AUG 11 1981		25b. REGISTRAR'S SIGNATURE Francis Gasch			

NAME	DATE	TIME	LOCATION	REMARKS
JOHN DOE	1945	10:30	101	...
JANE DOE	1945	11:00	101	...
JOHN DOE	1945	11:30	101	...
JANE DOE	1945	12:00	101	...
JOHN DOE	1945	12:30	101	...
JANE DOE	1945	13:00	101	...
JOHN DOE	1945	13:30	101	...
JANE DOE	1945	14:00	101	...
JOHN DOE	1945	14:30	101	...
JANE DOE	1945	15:00	101	...
JOHN DOE	1945	15:30	101	...
JANE DOE	1945	16:00	101	...
JOHN DOE	1945	16:30	101	...
JANE DOE	1945	17:00	101	...
JOHN DOE	1945	17:30	101	...
JANE DOE	1945	18:00	101	...
JOHN DOE	1945	18:30	101	...
JANE DOE	1945	19:00	101	...
JOHN DOE	1945	19:30	101	...
JANE DOE	1945	20:00	101	...
JOHN DOE	1945	20:30	101	...
JANE DOE	1945	21:00	101	...
JOHN DOE	1945	21:30	101	...
JANE DOE	1945	22:00	101	...
JOHN DOE	1945	22:30	101	...
JANE DOE	1945	23:00	101	...
JOHN DOE	1945	23:30	101	...
JANE DOE	1945	00:00	101	...

...

FOR
1- STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 2 1 7 4 7

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) LENNA G. MULITZ			2a. DATE OF DEATH MONTH DAY YEAR August 20, 1981		2b. HOUR 6:05a M
3 SEX Female	4 RACE White	5. DATE OF BIRTH MONTH DAY YEAR April 5, 1892		6 AGE (IN YEARS LAST BIRTHDAY) 89 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Russia	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10 CITY OR TOWN OF DEATH Rockville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Hebrew Home of Greater Wash.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY -----
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE Maryland	13b. COUNTY Montgomery	13c. CITY OR TOWN Rockville	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 6121 Montrose Road	
14. FATHER'S NAME FIRST MIDDLE LAST Morris Yaros			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ida Rabinowitz		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) ----- 578-38-0407D		17 INFORMANT ADDRESS Benjamin Mulitz; 2724 Blaine Dr., Ch Ch, Md.	
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary Arrest 1539 DUE TO, OR AS A CONSEQUENCE OF (b) s/p Surgery ca. Colon & A.S.H.D. DUE TO, OR AS A CONSEQUENCE OF (c) Hypertension; cardiovascular disease					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: Hypertension; cardiovascular disease					
19a. DATE OF OPERATION 8/81		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Ca Colon		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NO <input type="checkbox"/> WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22. I certify that (I) (this hospital) attended the deceased from July 18, 1979 to Aug 20, 1981 that (I) (we) last saw the deceased alive on Aug 19, 1981 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23a. SIGNATURE Kunjata H. Shah, M.D.				23b. DATE SIGNED 8/20/81	
23c. PHYSICIAN'S NAME (TYPE OR PRINT) KUNJLATA H. SHAH, M.D.				23d. ADDRESS 6121 Montrose Road; Rockville, Md.	
23e. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23f. DATE 8-21-81		23g. NAME OF CEMETERY OR CREMATORY Geo. Wash. Cemetery	
23h. LOCATION CITY OR TOWN COUNTY STATE Hyattsville, Maryland		24 FUNERAL DIRECTOR NAME ADDRESS Danzansky-Goldberg Chapels; 1170 Rockville Pike			
25. DATE REC'D. BY REGISTRAR		26. REGISTRAR'S SIGNATURE Aug 24 1981			

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TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use on the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene plus to burial, cremation, or removal.
IMPORTANT. If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Albert M. Murphy			2a. DATE OF DEATH MONTH DAY YEAR August 29, 1981			2b. HOUR 8:50AM			
3. SEX male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR Feb. 03, 1891		6. AGE (IN YEARS LAST BIRTHDAY) 90		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, Md.			
10. CITY OR TOWN OF DEATH Olney		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery Gen. Hospital, Olney, Md.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Tinsmith		12b. KIND OF BUSINESS OR INDUSTRY Roof	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY Mont.		13c. CITY OR TOWN Olney		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 3416 N. High St.	
14. FATHER'S NAME FIRST MIDDLE LAST Michael Joseph Murphy				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Caroline Elizabeth Riggs					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no		16b. SOCIAL SECURITY NO. 217-32-1388		17. INFORMANT ADDRESS Michael Douglas Howes, Sr. Wheaton, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Complete Heart Failure 4292 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Chronic Disease DUE TO, OR AS A CONSEQUENCE OF (c) 5 years DUE TO, OR AS A CONSEQUENCE OF									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Left V.A. 2 N Hemiparesis 1 day									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		19c. AUTOPSY YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 8/30/81 to 8/30/81 , that (I) (two) lost saw the deceased alive on 8/30/81 above, (I) (we) (did) (did) view the body after death.									
22b. SIGNATURE C. H. L. ...		22c. DEGREE MD		22d. ATTENDING PHYSICIAN PHYSICIAN		22e. MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22f. DATE SIGNED 8/30/81	
22g. PHYSICIAN'S NAME (TYPE OR PRINT) C. H. L. ...				22h. ADDRESS 8111 Bx Pkwy Dr, Olney, Md					
23a. BURIAL, CREMATION, REMOVAL (SP) Burial		23b. DATE Sept. 2, 1981		23c. NAME OF CEMETERY OR CREMATORY St. Mary's Catholic		23d. LOCATION Rockville Mort. Md.			
24. FUNERAL DIRECTOR NAME ADDRESS FRANCIS H. BARBER LAYTONSVILLE, M.D. 20879				25a. DATE REC'D. BY REGISTRAR SEP 2 1981					

Albert H. Knight
Guest 22, 1912

White
Feb. 23, 1912

U.S.A.
Montgomery County

Montgomery Co. Hospital, Chevy Chase
Montgomery Co. Hospital

Montgomery Co. Hospital

Montgomery Co. Hospital

Montgomery Co. Hospital

Montgomery Co. Hospital

Montgomery Co. Hospital

Montgomery Co. Hospital

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Montgomery Co. Hospital

Montgomery Co. Hospital

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH													
1. FOR STATE REGISTRAR					REG. NO.								
1. DECEASED NAME (TYPE OR PRINT) LARULEE THERESA MURPHY					2a. DATE OF DEATH MONTH DAY YEAR AUG. 29 81					2b. HOUR 1:44p.m.			
3 SEX Female		4 RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR 8 2 21		6. AGE (IN YEARS LAST BIRTHDAY) 60 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.							
10. CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hosp.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired			12b. KIND OF BUSINESS OR INDUSTRY				
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland					13b. COUNTY P.G.		13c. CITY OR TOWN Hyattsville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 7221 24th Place,	
14. FATHER'S NAME FIRST MIDDLE LAST Moses Jefferies					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Evelyn Pinkert								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR NO OR UNKNOWN) No					16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 578-22-0557		17. INFORMANT ADDRESS Willie E. Murphy/7221 24th Pl. Hyatts. Maryland						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute cardiac arrest</u> <u>4360</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Ventricular Fibrillation</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Myocardial Infarction of Brain Stem</u>										APPROXIMATE PERIOD BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Hypertension</u>													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (my (this hospital)) attended the deceased from <u>8-27-81</u> , 19 <u>81</u> , to <u>8-29-81</u> , 19 <u>81</u> , that (I (we)) lost saw the deceased alive on <u>8-29-81</u> , 19 <u>81</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I (we) (did) (did not) view the body after death.)													
22b. SIGNATURE <u>Charles Franklin Jr</u>					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <u>8-29-81</u>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Charles L Franklin Jr</u>					22e. ADDRESS <u>11200 Lockwood Dr. Silver Spring Md 20901</u>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 9-3-81		23c. NAME OF CEMETERY OR CREMATORY Lincoln Mem. Cem.			23d. LOCATION CITY OR TOWN COUNTY STATE Suitland P.G. Maryland					
24. FUNERAL DIRECTOR NAME MARSHALL'S FUNERAL HOME, INC. 4217 9th St., NW/Washington, D.C.					DATE REC'D BY VITALS DIVISION SEP 5 1981								

1. The first part of the report is a summary of the work done during the year. It is divided into two main sections: a general summary and a detailed account of the work done in each of the four departments.

2. The second part of the report is a detailed account of the work done in each of the four departments. It is divided into four sections: a general summary of the work done in each department, a detailed account of the work done in each of the four departments, and a summary of the work done in each of the four departments.

3. The third part of the report is a summary of the work done in each of the four departments. It is divided into four sections: a general summary of the work done in each department, a detailed account of the work done in each of the four departments, and a summary of the work done in each of the four departments.

4. The fourth part of the report is a summary of the work done in each of the four departments. It is divided into four sections: a general summary of the work done in each department, a detailed account of the work done in each of the four departments, and a summary of the work done in each of the four departments.

5. The fifth part of the report is a summary of the work done in each of the four departments. It is divided into four sections: a general summary of the work done in each department, a detailed account of the work done in each of the four departments, and a summary of the work done in each of the four departments.

TO HOSPITAL: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 2 1 7 5 0

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Edward J. Napoli			2a. DATE OF DEATH MONTH DAY YEAR August 28, 1981			2b. HOUR 5:18A M				
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR March 17, 1920		6. AGE (IN YEARS LAST BIRTHDAY) 61 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash, D.C.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.				
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Plumber		12b. KIND OF BUSINESS OR INDUSTRY Retired		
13a. STATE Md.			13b. COUNTY Montgomery		13c. CITY OR TOWN S.S.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1832 Arcola Avenue	
14. FATHER'S NAME FIRST MIDDLE LAST Joseph Napoli			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Blanche Inscob							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES) WWII		17. INFORMANT ADDRESS Ethel M. Napoli (Wife) Same as above					

II. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

5334 IMMEDIATE CAUSE (a) gastrointestinal hemorrhage
DUE TO, OR AS A CONSEQUENCE OF due to peptic ulcer
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) c shock
DUE TO, OR AS A CONSEQUENCE OF corticosteroid therapy
(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
1 wk

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):
severe chronic obstructive pulmonary disease

19a. DATE OF OPERATION 8/21/81 8/14/81		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>bleeding peptic ulcer</u> <u>perforated peptic ulcer</u>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (this hospital) attended the deceased from <u>7/11, 1981</u> to <u>8/28, 1981</u> , that I (we) lost <u>8/28, 1981</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I/we) did/did not view the body after death.							
22b. SIGNATURE <u>Barry N. Rosenbaum, M.D.</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8/28/81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Barry N. Rosenbaum, MD				22e. ADDRESS 3720 Farragut Ave. Kensington, Md.			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/31/81		23c. NAME OF CEMETERY OR CREMATORY Washington National		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland PG Maryland	
24. FUNERAL DIRECTOR NAME HINES/RINALDI FUNERAL HOME				25a. DATE REC'D. BY REGISTRAR SEP 01 1981			
25b. REGISTRAR'S SIGNATURE <u>James J. Hines</u>							

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August 22, 1961

Edward J. Napoli

White

Male

Holy Cross

Palmer Springs

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Blanchin

Napoli

Joseph

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3725 Tenthred Ave. - Washington, D.C.

Harry M. Rosenbaum, 1961

SEP 0 1 1961

RECEIVED

U.S. DEPARTMENT OF JUSTICE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 27 hours of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examination must be completed by a physician.FOR
1. STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 2 1 7 5 1

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST DENNIS NMI NEDZEL			2a. DATE OF DEATH MONTH DAY YEAR August 7, 1981		2b. HOUR 12:05AM
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR April 19, 1944	6. AGE (IN YEARS LAST BIRTHDAY) 37 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN
7. BIRTHPLACE (STATE OR FOREIGN) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD		
10. CITY OR TOWN OF DEATH Bethesda	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Clinical Center, NIH, Bethesda, MD		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Classified Nat'l Security Agency		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Maryland	13b. COUNTY Howard	13c. CITY OR TOWN Ellicott City	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Stanley Nedzel		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Cecelia Wasolowski			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. 216-42-0027	17. INFORMANT ADDRESS Mrs. Dayle P. Nedzel (Wife) Same		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 1729 Metastatic Melanoma IMMEDIATE CAUSE (a) Metastatic Melanoma DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 yrs.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
9a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from July 5, 1981 to August 7, 1981 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on August 7, 1981 and that <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above <input checked="" type="checkbox"/> (we) did <input type="checkbox"/> (we) did not view the body after death.					
22b. SIGNATURE <i>[Signature]</i>		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 8/7/81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Weiland, Douglas		22e. ADDRESS National Institutes of Health Clinical Center, Bethesda, MD 20205			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE Aug. 10, 1981	23c. NAME OF CEMETERY OR CREMATORY St Augustines		23d. LOCATION CITY OR TOWN COUNTY STATE Elkridge, Howard, Maryland	
24. FUNERAL DIRECTOR NAME ADDRESS Harry H Witzke 4112 Columbia Rd. Ellicott City		25a. DATE REC'D. BY REGISTRAR AUG 10 1981		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

BP

1947-1948
[Faint, mostly illegible text and markings, possibly bleed-through from the reverse side of the page. Some words like "Howard", "Lester", and "Cassidy" are faintly visible.]



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 1 2 1 7 5 2			
1. FOR STATE REGISTRAR				CERTIFICATE OF DEATH			
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH			
FIRST MIDDLE LAST Gotthelf Friedrich Neuhaeuser				MONTH DAY YEAR August 2, 1981			
3. SEX Male				4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR March 4, 1897	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Germany				7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH Chevy Chase				11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4602 Chevy Chase Blvd.			
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Interpreter				12b. KIND OF BUSINESS OR INDUSTRY Justice Dept.			
13a. STATE Maryland				13b. CITY OR TOWN Montgomery Chevy Chase			
14. FATHER'S NAME FIRST MIDDLE LAST Ernst Otto Neuhaeuser				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Marie Helene Mueller			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATE) 1924-1928		17. INFORMANT ADDRESS Edna Earl Neuhaeuser, Same as #13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cachexia. 1519 DUE TO, OR AS A CONSEQUENCE OF: (b) metastatic carcinoma. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Primary gastric adenocarcinoma.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1-2 months 28 Probable 5 Serial mts.			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): —							
19. DATE OF OPERATION June 29, 1981				20. CONDITION FOR WHICH OPERATION WAS PERFORMED Breast and gastric carcinoma.		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (the undersigned) attended the deceased from July 30, 1981 to August 2, 1981 , that (I) (we) lost the deceased on August 2, 1981 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above.							
22b. SIGNATURE George A. Gray, M.D.				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED August 3, 1981	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) George A. Gray, M.D.				22e. ADDRESS 6917 Arlington Road Bethesda, Maryland 20814			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE August 7, 1981		23c. NAME OF CEMETERY OR CREMATORY National Mem. Park	
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Homes, P.A. Bethesda, Maryland				23d. LOCATION CITY OR TOWN COUNTY STATE Falls Church, Virginia		25a. DATE REC'D. BY REGISTRAR AUG 7 1981	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This form may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health department with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

DHMH - 16 50M 1/81
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 2 1 7 5 3

1. FOR STATE REGISTRAR		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) Roy V. NEW		2a. DATE OF DEATH MONTH DAY YEAR August 4 1981	
3. SEX Male		7b. HOUR 11:50P _M	
4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Sept. 29, 1929	
6. AGE (IN YEARS LAST BIRTHDAY) 51		7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Elberton, Georgia	
7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery		10. CITY OR TOWN OF DEATH Bethesda	
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) National Naval Medical Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) U. S. Navy	
12b. KIND OF BUSINESS OR INDUSTRY Retired		13a. STREET ADDRESS 11589 North Shore Drive	
13b. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13c. CITY OR TOWN Reston	
14. FATHER'S NAME FIRST MIDDLE LAST Fred New		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lela Bachelor	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. Korea/Viet Nam 254 36 0601	
17. INFORMANT ADDRESS Herndon, Va.		17. INFORMANT Kevin New c/o Ruby Martin 2540 Centreville Rd	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 5679 IMMEDIATE CAUSE (a) BACTERIAL PERITONITIS COMPLICATING ADVANCED HEPATIC CIRRHOSIS. DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c)			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I/this hospital) attended the deceased from June 30, 1981, to Aug. 4, 1981, that (I/we) lost saw the deceased alive on Aug. 4, 1981, and that in (my/our) opinion death occurred on the date and hour and from the causes stated above. (We did not see the body after death.)			
22b. SIGNATURE G.M. Davis		22c. DATE SIGNED Aug. 5, 1981	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) G.M. DAVIS		22e. ADDRESS National Naval Medical Center, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial - Removal		23b. DATE 8/7/1981	
23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION CITY OR TOWN COUNTY STATE Arlington Arlington Va.	
24. FUNERAL DIRECTOR NAME Green Funeral Home		25a. DATE REC'D. BY REGISTRAR AUG 12 1981	
25b. REGISTRAR'S SIGNATURE Renee Jean Martin		25c. REGISTRAR'S SIGNATURE	



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W. D. Davis

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove (detach) pages 1 and 2 and file within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified in writing.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Raymond C Newlin			2a. DATE OF DEATH MONTH DAY YEAR 8 31 81			2b. HOUR 2 48 M	
3. SEX Male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 7 05 93		6. AGE (IN YEARS LAST BIRTHDAY) 88	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? US		8. MARried <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Self Employed		12b. KIND OF BUSINESS OR INDUSTRY CPA	
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Bethesda		13d. STREET ADDRESS 7501 Democracy #B222	
14. FATHER'S NAME George		15. MOTHER'S MAIDEN NAME Annie		16. ADDRESS Happerset			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATE) 577-12-5653		17. INFORMANT Hazel L. Newlin Same as item # 13			
18. CAUSE OF DEATH (Enter only one cause per line for 18a, 18b, 18c, 18d, 18e, 18f, 18g, 18h, 18i, 18j, 18k, 18l, 18m, 18n, 18o, 18p, 18q, 18r, 18s, 18t, 18u, 18v, 18w, 18x, 18y, 18z) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute pneumonia DUE TO, OR AS A CONSEQUENCE OF (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF (d) _____ (e) _____ (f) _____ (g) _____ (h) _____ (i) _____ (j) _____ (k) _____ (l) _____ (m) _____ (n) _____ (o) _____ (p) _____ (q) _____ (r) _____ (s) _____ (t) _____ (u) _____ (v) _____ (w) _____ (x) _____ (y) _____ (z) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____ Arteriosclerotic Cardiovascular Disease						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 days	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18; PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 8/24/81 to 8/30/81 that I (was) last saw the deceased alive on 8/29/81 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) see the body after death.							
22b. SIGNATURE Myron L. Lenkin		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8/31/81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MYRON L. LENKIN		22e. ADDRESS 2309 Shorefield Rd Wheaton MD.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9-2-81		23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Rockville, Md.	
24. FUNERAL DIRECTOR NAME Joseph Gawler's Sons, Inc. ADDRESS 5130 Wisc. Ave. N.W. Wash., D.C. 20016				25a. DATE REC'D. BY REGISTRAR SEP 2 1981			
				25b. REGISTRAR'S SIGNATURE James S. [Signature]			

UNITED STATES DEPARTMENT OF AGRICULTURE
BUREAU OF PLANT INDUSTRY
WASHINGTON, D. C.

Inventory

US

Plant Name
Quantity
Unit
Value
Total Value

Plant Name
Quantity
Unit
Value
Total Value

Plant Name
Quantity
Unit
Value
Total Value

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
1. FOR STATE REGISTRAR					8 1 2 1 / 5 5 REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) FIRST MARY MIDDLE ROSE LAST NISKOCH					2a. DATE OF DEATH MONTH DAY YEAR August 21, 1981			2b. HOUR 4:05A M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR June 1, 1916		6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 74 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New Jersey		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD			
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Clinical Center, NIH, Bethesda, MD				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Home	
13a. STATE New Jersey		13b. COUNTY Union		13c. CITY OR TOWN Linden		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1207-4 Stockton Circle 07036	
14. FATHER'S NAME FIRST MIDDLE LAST John Hlopko			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rose Not Available						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 157-10-0442			17. INFORMANT ADDRESS William Niskoch Same address #13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hepatorenal Failure</u> 1519 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Gastric Carcinoma</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH One week Months									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION July 23, 1981			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Gastric Carcinoma			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (this hospital) attended the deceased from July 12, 1981, to August 21, 1981, that (we) last saw the deceased alive on August 21, 1981, and that in (our) opinion death occurred on the date and hour and from the causes stated above. (we) did view the body after death.									
22b. SIGNATURE WF Sindelar						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1981 August 21,	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) WF SINDELAR						22e. ADDRESS National Institutes of Health Clinical Center, Bethesda, MD 20205			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE August 24, 1981		23c. NAME OF CEMETERY OR CREMATORY St. Gertrude's Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Colonia, New Jersey			
24. FUNERAL DIRECTOR'S NAME Robert A. Pumphrey Homes, P.A. Bethesda, Maryland						25a. DATE REC'D. BY REGISTRAR AUG 26 1981			

2



AUG 2 1981

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of cause.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8121756	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) Monte E. NOTTON						2a. DATE OF DEATH MONTH DAY YEAR August 6, 1981			2b. HOUR 6:00A M		
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR April 30 1925		6. AGE (IN YEARS LAST BIRTHDAY) 56 YRS		IF UNDER 1 YEAR MONTHS DAYS 0 0		IF UNDER 24 HRS HOURS MIN. 0 0	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wisconsin		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD.					
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) National Naval Medical Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) U.S. Air Force			12b. KIND OF BUSINESS OR INDUSTRY U.S. Govt.		
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Gaithersburg		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 8721 Oakmont Street			
14. FATHER'S NAME FIRST MIDDLE LAST Monte Notton						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Celia Terrangou					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 1945-65		17. INFORMANT Leona Notton		ADDRESS See item 13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: 4100 IMMEDIATE CAUSE (a) Acute myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 P.M.		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (a) (this hospital) attended the deceased from 1972 to Aug. 6 , 19 81 , that (we) lost saw the deceased alive on Aug. 6 , 19 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (Two) (did) (did not) view the body after death.											
22b. SIGNATURE Robert Chinn, Jr.						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED Aug. 6 1981		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert Chinn, Jr., M.D.						22e. ADDRESS National Naval Medical Center, Bethesda, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE August 10 1981		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION CITY OR TOWN COUNTY STATE Arlington Arlington Va.			
24. FUNERAL DIRECTOR NAME Robt. A. Pumphrey Funeral Home Rockville, Md.						25a. DATE REC'D. BY REGISTRAR AUG 13 1981		25b. REGISTRAR'S SIGNATURE James J. H. H.			

2

1907

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 2 1 7 5 7

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Alexander S. Ornstein			2a. DATE OF DEATH MONTH DAY YEAR Aug 22 1981			2b. HOUR 5:30 AM				
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 9 19 05		6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York City		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.				
10. CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sligo Gardens Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Court Reporter		12b. KIND OF BUSINESS OR INDUSTRY House of Representative		
13a. STATE Md.			13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 9039 Sligo Creek Parkway Apt. 810	
14. FATHER'S NAME THEODORE			15. MOTHER'S MAIDEN NAME CLARA			16. PERLMUTTER				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 577-03-2426		17. INFORMANT Freda Ornstein (Same as # 13)					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) myocardial infarction DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) atherosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 yrs							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Recent Trauma resolved, ambulatory dysfunction							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) this hospital attended the deceased from May 1981, to 8-22 1981, that (1) we last saw the deceased alive on 8-5-1981, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (1) we (we) did (did not) view the body after death.							
22b. SIGNATURE J. Kipich MD		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8-22-81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John Kipich Jr MD		22e. ADDRESS 344 UNIVERSITY BLVD @ SILVER SPRING MD 20901					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 8/24/1981		23c. NAME OF CEMETERY OR CREMATORY KING DAVID MEM. GARDEN		23d. LOCATION CITY OF TOWN COUNTY STATE FALLS CHURCH, VIRGINIA	
24. FUNERAL DIRECTOR DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME 232 CARROLL STREET, N.W., WASHINGTON, D. C.				25a. DATE REC'D. BY REGISTRAR AUG 26 1981			

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30/12

Handwritten text, possibly a signature or name.

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1881 13 JUL

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 21758					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Margaret Hunter Ostrom										2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR 8/16 1981		2b. HOUR 7:06 PM			
3. SEX female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 5 1 26		6. AGE (IN YEARS) LAST BIRTHDAY YRS. 55		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 8 16 1981		2d. HOUR 7:06 PM			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Scotland				7b. CITIZEN OF WHAT COUNTRY? Scotland				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH Bethesda				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker				12b. KIND OF BUSINESS OR INDUSTRY			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13a. STATE Maryland				13b. CITY OR TOWN Montgomery				13c. CITY OR TOWN Rockville			
14. FATHER'S NAME FIRST MIDDLE LAST James Hunter				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Isabella Burt				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS 340 Broadwood Drive			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no				16b. SOCIAL SECURITY NO. 040-20-1055				17. INFORMANT ADDRESS John C. Ostrom/husband / same as 13d							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 5679 IMMEDIATE CAUSE (a) Acute Peritonitis DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPS (BO) YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE (body Only)							
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .															
ACTUAL SIGNATURE H. Guard				TITLE (SPECIFY) Assistant				M.D. MEDICAL EXAMINER				DATE SIGNED 8/18/81			
EXAMINER'S NAME (TYPE OR PRINT) Hormez R. Guard, M.D.				ADDRESS 111 Penn Street, Baltimore, MD 21201											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation				23b. DATE 8-21-81		23c. NAME OF CEMETERY OR CREMATORY Lee's Crematory				23d. LOCATION (CITY OR TOWN) COUNTY STATE Washington D.C.					
24. FUNERAL DIRECTOR NAME Hines/Rinaldi F.H. Silver Spring, Md.				25. DATE REC'D. BY REGISTRAR AUG 21 1981				26. REGISTRAR'S SIGNATURE Hormez R. Guard							



040-10-1022 John C. Ostrom/ashland / same as 101
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John C. Ostrom/ashland / same as 101
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John C. Ostrom/ashland / same as 101
Tadpole
Lure

(only only)

040-10-1022 John C. Ostrom/ashland / same as 101
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040-10-1022
John C. Ostrom/ashland / same as 101
Tadpole
Lure
040-10-1022
John C. Ostrom/ashland / same as 101
Tadpole
Lure

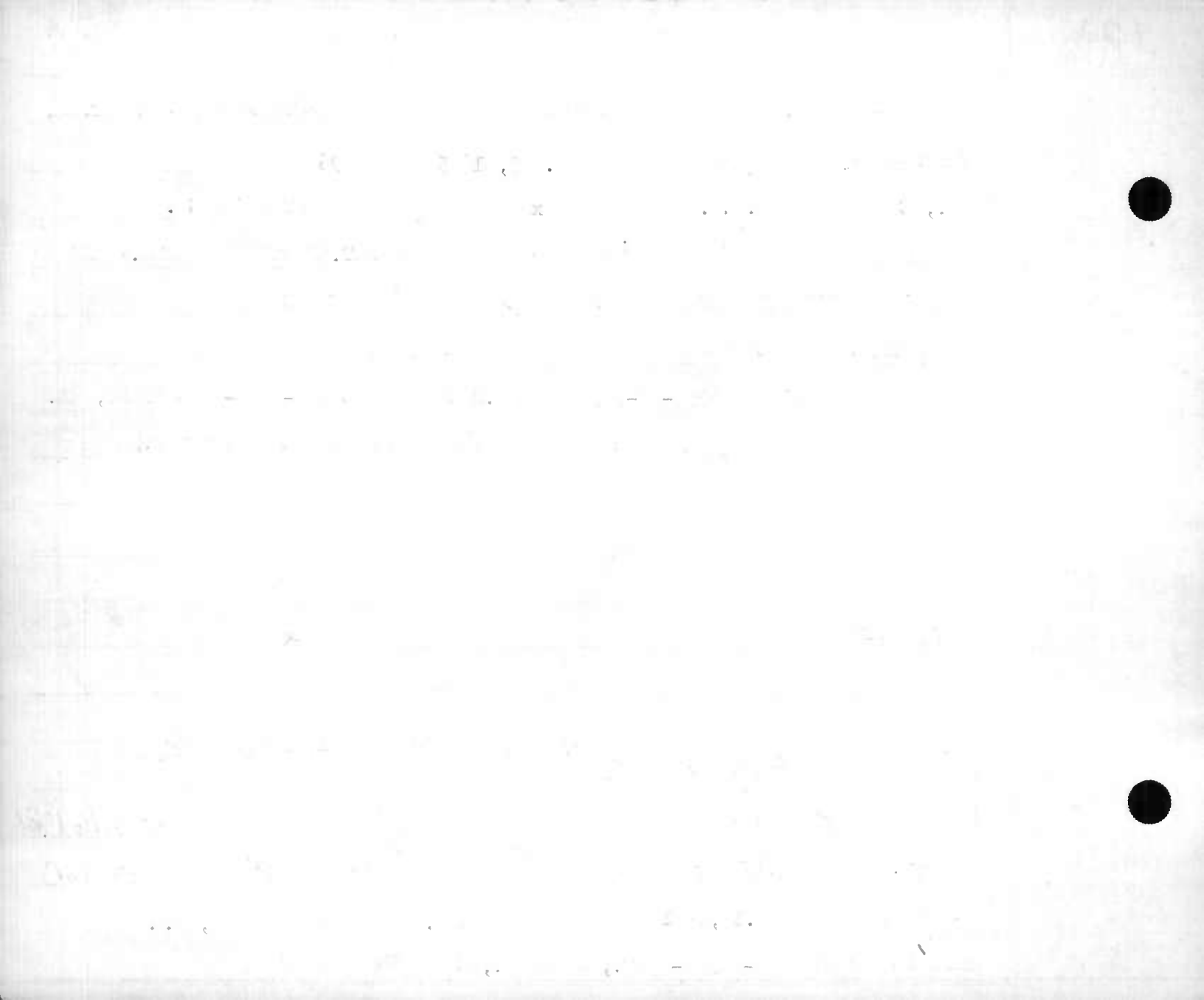
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 1 2 1 7 5 9			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) AMELIA — OUTER BRIDGE				2a. DATE OF DEATH MONTH DAY YEAR AUGUST 16, 1981		2b. HOUR 12:57 AM	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR APR. 3, 1885		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS HOURS MIN. 96	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASH., DC		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY CO. MD.	
10. CITY OR TOWN OF DEATH ROCKVILLE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NATIONAL LUTHERAN HOME		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RET. NURSE		12b. KIND OF BUSINESS OR INDUSTRY REG. NURSE	
13a. STATE RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN VIRGINIA UNKNOWN TROUTVILLE				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS RTE 3	
14. FATHER'S NAME FIRST MIDDLE LAST FREDERICK SCHIEMANN				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST HENRIETTA SCHULA			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) NONE		17. INFORMANT ADDRESS REV. RICHARD REICHARD- NLH- ROCKVILLE, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CLINICAL ASCVD with Cerebrovascular Accident 4292 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH MONTHS	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)							
19a. DATE OF OPERATION NONE		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from Nov 6, 1978 to AUG. 16, 1981 , that (I) (we) lost saw the deceased alive on AUG. 16, 1981 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE THOMAS DOOLEY, M.D.		22c. DATE SIGNED AUG. 16 1981				22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
22e. PHYSICIAN'S NAME (TYPE OR PRINT) THOMAS DOOLEY, M.D.		22f. ADDRESS SANDY SPRING RD. OLNEY, MD.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE AUG. 19, 1981		23c. NAME OF CEMETERY OR CREMATORY PROSPECT HILL CEM.		23d. LOCATION CITY OR TOWN COUNTY STATE WASHINGTON, D.C.	
24. FUNERAL DIRECTOR NAME ADDRESS HYSONG FUNERAL HOME- 1300-N ST., NW WASH., DC				25a. DATE REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE AUG 24 1981			



1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Fannie Mae Padrick			2a. DATE OF DEATH MONTH DAY YEAR August 7 1981		2b. HOUR 12 4 M		
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR January 2, 1892		6. AGE (IN YEARS LAST BIRTHDAY) 89 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY County, MD.	
10. CITY OR TOWN OF DEATH Chevy Chase		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Chevy Chase Nursing Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Home	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)							
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Cabin John		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST William Marine		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Virginia N. Farr		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No			
16b. SOCIAL SECURITY NO. 239-16-3633		17. INFORMANT ADDRESS Same as item #13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardiac arrest 4292 DUE TO, OR AS A CONSEQUENCE OF arteriosclerotic cardiovascular disease yes DUE TO, OR AS A CONSEQUENCE OF (c) PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Smoking							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from Jan 24 1975 to 22 July 1981 that (I) (we) last saw the deceased alive on 22 July 1981 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If I (we) did not view the body after death)							
22b. SIGNATURE Horace W. Bernton		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8/7/81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Horace W. Bernton		22e. ADDRESS 4743 Bradley Blvd., Chevy Chase, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial/Removal		23b. DATE August 10, 1981		23c. NAME OF CEMETERY OR CREMATORY Forest Lawn Cemetery, Wilmington, NC.		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME Bethesda, Maryland Robert A. Pumphrey		ADDRESS Funeral Homes, P.A.		25a. DATE RECEIVED BY REGISTRAR AUG 14 1981			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filled within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 18 is marked or item 19 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8	1	2	1	7	6	1
1. FOR STATE REGISTRAR										REG. NO.						
1. DECEASED NAME FIRST MIDDLE LAST BRADSHAW W. PALMER										2a. DATE OF DEATH MONTH DAY YEAR AUG. 23, 1981				2b. HOUR 1050AM		
3. SEX Male		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR 11 30 98		6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS.		IF UNDER 1 YEAR MONTHS DAYS 82		IF UNDER 24 HRS HOURS MIN. 1050AM						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.										
10. CITY OR TOWN OF DEATH ROCKVILLE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SHADY GROVE ADVENTIST HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) FARMER		12b. KIND OF BUSINESS OR INDUSTRY								
13a. STATE MD.				13b. COUNTY MONTG.		13c. CITY OR TOWN DICKERSON		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 21201 Big Woods Rd.						
14. FATHER'S NAME FIRST MIDDLE LAST HARRISON PALMER				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST HENRIETTA MARTIN												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 220-12-3689		17. INFORMANT ADDRESS Florence Randolph (daughter) Same as #13										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia and anemia 1639 DUE TO, OR AS A CONSEQUENCE OF (b) Carcinoma of lungs with metastasis to brain DUE TO, OR AS A CONSEQUENCE OF (c) Hypertension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7-10 days 3-4 months						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Hypertension, Diabetes mellitus.																
19a. DATE OF OPERATION —				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED —				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE										
22a. I certify that (I) (this hospital) attended the deceased from Aug 4 , 19 81 , to Aug 23 , 19 81 , that (I) (we) lost saw the deceased alive on Aug 23 , 19 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																
22b. SIGNATURE Ruben P. Coscia, M.D.				DEGREE M.D.				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8/24/81						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) RUBEN C. COSCIA, M.D.				22e. ADDRESS 7529 REDLAND ROAD DEERWOOD, MD. 20815												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL				23b. DATE 8-28-81		23c. NAME OF CEMETERY OR CREMATORY WARREN Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Martinsburg Montg Md.						
24. FUNERAL DIRECTOR NAME George R. Snowden				24a. ADDRESS 246 N. WASH. ST. ROCKVILLE, MD.		25a. DATE REC'D. BY REGISTRAR AUG 21 1981		25b. REGISTRAR'S SIGNATURE James J. [Signature]								

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[Faint, illegible handwriting covering the majority of the page]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 1 2 1 / 6 2			
1- FOR STATE REGISTRAR				REG. NO.			
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Infant Boy (B) Papadopoulos				2a. DATE OF DEATH MONTH DAY YEAR 8-16-81		2b. HOUR 2:10 AM	
3 SEX Male		4 RACE Caucasian		5 DATE OF BIRTH MONTH DAY YEAR 08 28 81		6 AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN 0 0 0 20	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD	
10 CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE VA		13b. CITY OR TOWN Falls Church		13c. STREET ADDRESS 3701 S. George Mason Dr Falls Church VA 22041			
14 FATHER'S NAME FIRST MIDDLE LAST Thomas Papaopoulos		15. MOTHER'S MAIDEN NAME FIRST MIDDLE Maria Morieti					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 7690		17 INFORMANT ADDRESS 3701 S. Geo. Mason Dr., Falls Ch., Va Thomas Papadopoulos Dr.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure DUE TO, OR AS A CONSEQUENCE OF (b) Hyaline Membrane Disease DUE TO, OR AS A CONSEQUENCE OF (c) Extreme Prematurity - 25 weeks gestation APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from August 15, 19 81, to August 16, 19 81, that (I) (we) last saw the deceased alive on 8/16, 19 81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE John Van Brakle MD		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8-16-81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOHN VAN BRAKLE		22e. ADDRESS Holy Cross Hospital - 1500 Forest Glen, SS MD 20901					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 8/18/81		23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria, Va.	
24 FUNERAL DIRECTOR NAME Waller		ADDRESS 8434 Ga. Ave Sil. Spr., Md		25a. DATE REC'D BY REGISTRAR AUG 19 1981		25b. REGISTRAR'S SIGNATURE [Signature]	

BP



5895000

Item 13 For
funeral home
8/24/81

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				812163			
1. FOR STATE REGISTRAR				REG. NO.			
1 DECEASED NAME (TYPE OR PRINT) Infant Girl Papadopoulos				2a. DATE OF DEATH 8-16-81			
3 SEX Female		4 RACE Caucasian		5 DATE OF BIRTH 08 15 81		6 AGE (IN YEARS LAST BIRTHDAY) — YRS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD	
10 CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOLY CROSS HOSPITAL		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY	
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) VA		13b COUNTY Falls Church		13c CITY OR TOWN Falls Church		13d STREET ADDRESS 3701 S. George Mason Dr	
14 FATHER'S NAME Thomas		15 MOTHER'S MAIDEN NAME Marieta		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO.	
17 INFORMANT Thomas Papadopoulos		18 ADDRESS 3701 S. Geo. Mason Dr., Falls Ch., Va.		19		20	
II CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure 7690 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Hyaline Membrane Disease DUE TO, OR AS A CONSEQUENCE OF (c) Extreme Prematurity - 25 week gestation				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22 I certify that (I) (this hospital) attended the deceased from August 15 , 19 81 , to August 16 , 19 81 , that (I) (we) lost saw the deceased alive on 8/16 , 19 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did (I) did not view the body after death.)							
22b SIGNATURE John Van Brakle				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED 8-16-81	
22d PHYSICIAN'S NAME (TYPE OR PRINT) JOHN VAN BRAKLE				22e ADDRESS Holy Cross Hospital 1500 Forest Glen Silver Spring, Md 20901			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b DATE 8/18/81		23c NAME OF CEMETERY OR CREMATORY Metropolitan Crematory		23d LOCATION CITY OR TOWN COUNTY STATE Alexandria, Va.	
24 FUNERAL DIRECTOR NAME Clark W. Wynn ADDRESS 8434 Ga. Ave Sil. Spr., Md.				25a DATE REC'D. BY REGISTRAR AUG 19 1981 25b REGISTRAR'S SIGNATURE James J. [Signature]			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Item #236 per phone call w/Fun. DEPARTMENT OF HEALTH AND MENTAL HYGIENE
1. FOR Home 8/31/81 rc CERTIFICATE OF DEATH

8 1 2 1 / 6 4

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Xavier Heesup Park			2a. DATE OF DEATH MONTH DAY YEAR August 25, 1981			2b. HOUR 5:15 P _M			
3. SEX Male		4. RACE Korean		5. DATE OF BIRTH MONTH DAY YEAR March 5, 1930		6. AGE (IN YEARS LAST BIRTHDAY) 51 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Korea		7b. CITIZEN OF WHAT COUNTRY? Korean		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD			
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Clinical Center, NIH, Bethesda, Md.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Self-Employed Teacher Director Schools			
13a. STATE Ohio		13b. CITY OR TOWN Columbus		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS 516 Stinchcomb Dr. #4		43202	
14. FATHER'S NAME FIRST MIDDLE LAST Ju Sik Park			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Yoo UNK						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) None		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 301 74 2320		17. INFORMANT ADDRESS Mrs. Young Soon Park (wife) same as patient					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage 1550 DUE TO, OR AS A CONSEQUENCE OF (b) Hepatoma - hepatic carcinoma Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION Aug. 25, 1981		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Intra operative death				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from August 20, 1981, to August 25, 1981, that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on August 25, 1981, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (do not) view the body after death.									
22b. SIGNATURE Steven M. Keller MD						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED August 25, 1981	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) STEVEN M. KELLER				22e. ADDRESS National Institutes of Health Clinical Center, Bethesda, Md. 20205					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/26/81		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven		23d. LOCATION CITY OR TOWN COUNTY STATE S.S. MONT. Md.			
24. FUNERAL DIRECTOR NAME Hines/Rinaldi F.H.11800 N.H.Ave.S.S.Md.						25a. DATE REC'D. BY REGISTRAR AUG 31 1981			
						25b. REGISTRAR'S SIGNATURE [Signature]			

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 2 1 7 6 5

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST BARBARA Wilson PARKER			2a. DATE OF DEATH MONTH DAY YEAR AUGUST, 4, 1981		2b. HOUR 3:40pm
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR DEC. 20, 1924		6. AGE (IN YEARS LAST BIRTHDAY) 56 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New Hampshire	7b. CITIZEN OF WHAT COUNTRY? United States	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD	
10. CITY OR TOWN OF DEATH BETHESDA	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Clinical Center, NIH, Beth. Md.		12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) Administrative Assistant to Styles Bridge		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE MARYLAND		13b. COUNTY Montgomery	13c. CITY OR TOWN POTOMAC	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 9520 ACCORD DRIVE 20854
14. FATHER'S NAME FIRST MIDDLE LAST Frank Paddock Wilson		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Laura Drost			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 002-12-3832		17. INFORMANT ADDRESS EVAN J. PARKER JR. (husband) Same as item 13e	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest 4828 DUE TO, OR AS A CONSEQUENCE OF (b) Respiratory Failure DUE TO, OR AS A CONSEQUENCE OF (c) hegionnaire's Disease				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes 10 days 12 days	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Systemic Lupus Erythematosus					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN DETERMINING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from JULY 23 , 19 81 , to AUGUST 4 , 19 81 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on AUGUST 4 , 19 81 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, (I/we) (did) (do not) view the body after death.					
22b. SIGNATURE Margaret Parker no		DEGREE no		22c. DATE SIGNED 8/5/81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) margaret Parker no		22e. ADDRESS NATIONAL INSTITUTES OF HEALTH CLINICAL CENTER, BETHESDA, MD 20205			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation	23b. DATE August 6, 1981	23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory, Alexandria, Virginia	23d. LOCATION CITY OR TOWN COUNTY STATE
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Homes, P.A., Bethesda, Maryland		25a. DATE REC'D. BY REGISTRAR AUG 10 1981	25b. REGISTRAR'S SIGNATURE <i>James J. Hartman</i>

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



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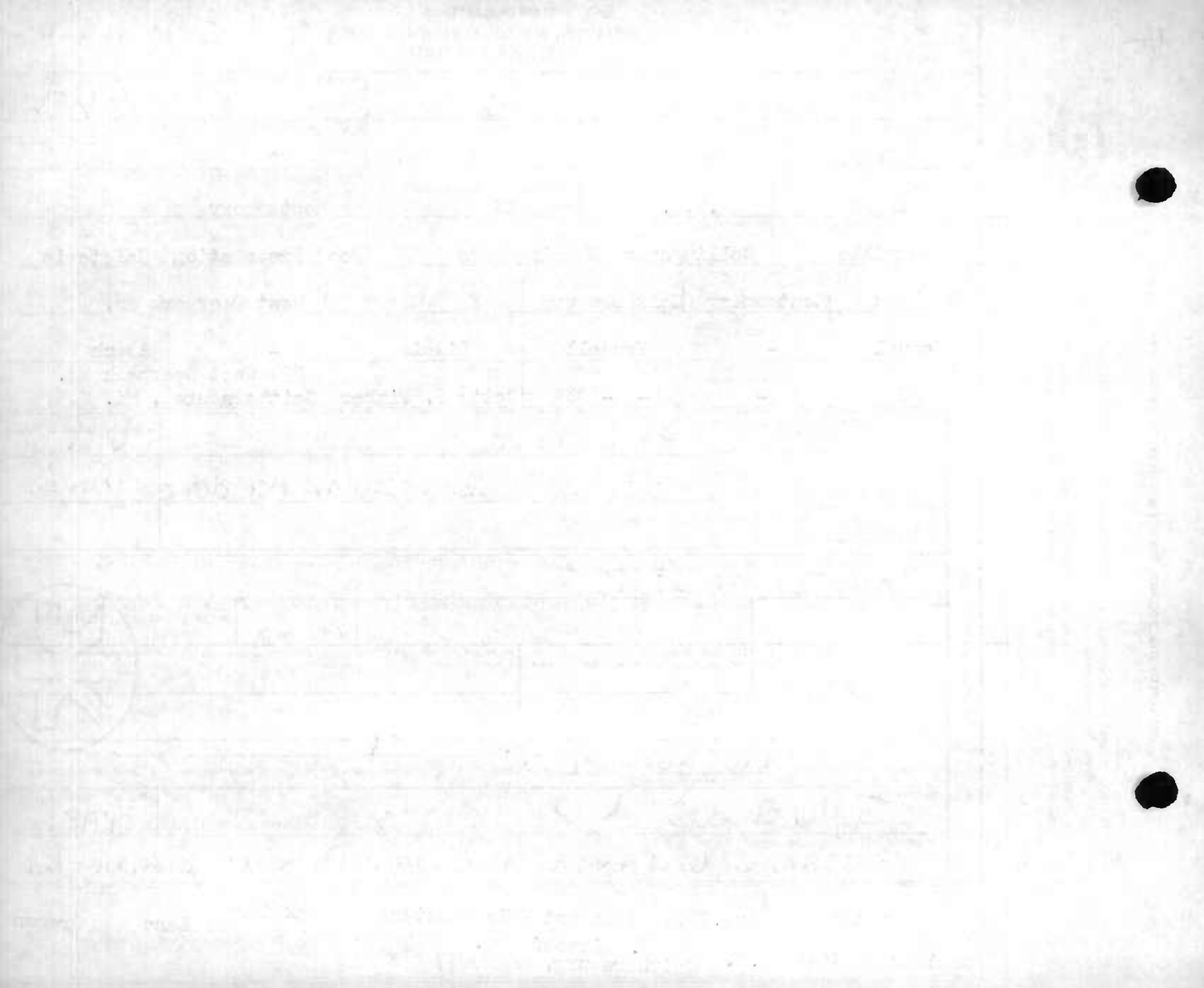
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR			REG. NO.						
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR
Ida J. Parks						8 / 7 / 81			950A M
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR IF UNDER 24 HRS	
Female		White		March 6 1909		72 YRS.		MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Texas		U.S.A.				Montgomery MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Rockville		Collingswood Nursing Home				Food Preparation		Cafeteria	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13a. INSIDE CITY LIMITS?			13b. STREET ADDRESS			
13a. STATE 13b. COUNTY 13c. CITY OR TOWN			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			294 West Deerpark Rd.			
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST						
Samuel - Yandell			Lizzie - Reach						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS				
No			544-44-1389		Betty P. Fisher 294 West Deerpark Rd. Gaithersburg, Md. 20877				
18. CAUSE OF DEATH (Enter only one cause per line for 10a, 10b, and 10c.)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) Pneumonia									2 days
4360 } DUE TO, OR AS A CONSEQUENCE OF (b) Massive Cerebrovascular Accident									1 month
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
Diabetes mellitus									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M.		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
			19						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from Jan 19 81 to Jan 19 81, that (I) (we) last saw the deceased alive on early July 19 81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
SD Withrow, M.D.								8/7/81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS						
SUSAN J. WITHROW			15E Deer Park Dr Gaithersburg Md						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE		
Burial			Aug. 15, 1981		Forest Vale Cemetery		Oakridge Lane Oregon		
24. FUNERAL DIRECTOR NAME			24b. ADDRESS			24c. DATE RECEIVED BY REGISTRAR			
Gartner Sandison F.H.			316 E. Diamond Ave. Gaithersburg, Md 20877			AUG 12 1981			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers, Pages 1 and 2 should be filed with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
1. STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) GLADYS D. ELIZABETH PASKE		2a. DATE OF DEATH MONTH DAY YEAR 8 22 81		2b. HOUR 9:15 AM
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR 7 14 04		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) ILLINOIS	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
10. CITY OR TOWN OF DEATH SILVER SPRING		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOLY CROSS HOSPITAL		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE MARYLAND		13b. COUNTY MONTGOMERY	13c. CITY OR TOWN SILVER SPRING	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST FERMIE TEWEL		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ESTELLA SAWYER		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 394-12-6345		17. INFORMANT ADDRESS MAX P. PASKE SAME AS 13 HUSBAND
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Anterior Myocardial Infarct 4 days 4100 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 8/17 P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 8/17 19 81 to 8/22 19 81 that (I) (we) last saw the deceased alive on 8/22 19 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE Ira Tanker MD		22c. DATE SIGNED 8/22/81		22d. DEGREE MD
22e. PHYSICIAN'S NAME (TYPE OR PRINT) Ira Tanker		22f. ADDRESS SILVER SPRING, MARYLAND		
23a. BURIAL, CREMATION, REMOVAL (METHOD) BURIAL		23b. DATE 8/28/81		23c. NAME OF CEMETERY OR CREMATORY WILDWOOD CEMETERY
23d. LOCATION CITY OR TOWN COUNTY STATE SHEBOYGAN SHEBOYGAN WISC.				
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS		25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE SEP 2 1981		
500 UNIV. BLVD., W., SILVER SPRING, MD. 20901				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 27 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
1- FOR STATE REGISTRAR					8 1 2 1 7 6 8 CERTIFICATE OF DEATH				
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH MONTH DAY YEAR				
James E. Pennoyer					August 30, 1981				
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		2b. HOUR	
male		white		Nov. 12, 1895		85 years		2:00PM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH			
Wyoming		U.S.A.				Montgomery County, MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Olney		Montgomery Gen. Hospital, Olney, Md.				Farmer		Farm	
13a. STATE					13b. CITY OR TOWN		13c. STREET ADDRESS		
Penn.					York		Rt. #1		
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME				
John Wesley Pennoyer					Mary Lee Norman				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS		
Yes					WWI		13 Goshen Ct. William E. Norman Gaithersburg, Md. 20879		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY									
4292 IMMEDIATE CAUSE (a) Atherosclerotic Cardiovascular Disease									
DUE TO, OR AS A CONSEQUENCE OF									
b) _____									
DUE TO, OR AS A CONSEQUENCE OF									
c) _____									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (d)									
Chronic Obstructive Lung Disease									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 8/27, 19 81, to Aug 30, 19 81, that (I) (we) last saw the deceased alive on 8/30/81, 19 81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE					DEGREE			22c. DATE SIGNED	
Raymond Bass					MD			8/30/81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS				
10620 Georgia Ave Silver Spring					RAYMOND BASS M.D.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION			
Burial - Removal		Sept. 2, 1981		Emanuel's Cemetery		Lewisberry York Co. Penn.			
24. FUNERAL DIRECTOR NAME					25a. DATE REC'D. BY REGISTRAR				
FRANCIS H. BARBER					25b. REGISTRAR'S SIGNATURE				
LAYTONSVILLE, MD. 20879					SEP 3 1981				

James H. Thompson August 20, 1901

White male
U.S.A.
Montgomery Gen. Hospital, Montgomery, Ala.
X

11-12

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by him or her, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a post-mortem examination must be performed.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 1 2 1 7 6 9			
1 - STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <i>Lily A. PERERA</i>				2a. DATE OF DEATH		2b. HOUR	
				MONTH DAY YEAR <i>8 4 81</i>		4:35 P.M.	
3. SEX FEMALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR <i>APRIL 23, 1900</i>		6. AGE (IN YEARS (LAST BIRTHDAY)) <i>81</i> YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) SRI LANKA		7b. CITIZEN OF WHAT COUNTRY? SRI LANKA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH <i>Silver Spring</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Holy Cross Hospital</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MARYLAND		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN ROCKVILLE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS 13534 GRENOBLE DRIVE		14. FATHER'S NAME FIRST MIDDLE LAST J. SENANAYAKE		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ISOBEL		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO	
16b. SOCIAL SECURITY NO. NONE		17. INFORMANT ADDRESS HYACINTH WIKREMANAYAKE SAME AS 13 DAUGHTER		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Heart Failure</i> 4280 DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 week</i>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>Diabetes Mellitus</i>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>2 May</i> , 19 <i>81</i> , to <i>4 May</i> , 19 <i>81</i> , that (I) (we) lost saw the deceased alive on <i>3 May</i> , 19 <i>81</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>[Signature]</i>		DEGREE <i>MD</i>		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>3 May 81</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Michael G. Benichou</i>		22e. ADDRESS <i>11120 New Hampshire Ave. S.S., U.S.</i>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 8/8/81		23c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN		23d. LOCATION CITY OR TOWN COUNTY STATE SILVER SPRING MONT MD.	
24. FUNERAL DIRECTOR FRANCIS J. COLLINS 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	
				AUG 7 1981			



X



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										81 21 / 70	
1- FOR STATE REGISTRAR										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) Consuelo Perez					2a. DATE OF DEATH MONTH DAY YEAR 8 / 29 / 81			2b. HOUR 1:45 PM			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 7 5 92		6. AGE (IN YEARS LAST BIRTHDAY) 89 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Spain		7b. CITIZEN OF WHAT COUNTRY? Permanent Resident		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.					
10. CITY OR TOWN OF DEATH Olney		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery General Hosp.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) retired		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE md.					13b. CITY OR TOWN Montgomery Silver Spring		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS 1705 Chestermill Rd.		
14. FATHER'S NAME FIRST MIDDLE LAST Jacinto Perez					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Maria Alvarez						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) None			16b. SOCIAL SECURITY NO. 212 68 0022		17. INFORMANT (ADDRESS) (Grand) 1705 Chester Mill Maria Sontheimer (Daughter) S.S.Md. Rd.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 4275 IMMEDIATE CAUSE (a) Anoxic encephalopathy DUE TO, OR AS A CONSEQUENCE OF (b) Cardiopulmonary arrest DUE TO, OR AS A CONSEQUENCE OF (c) CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 8/26 , 19 81 , to 8/29 , 19 81 , that (I) (we) last saw the deceased alive on 8/29 , 19 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Jay Weiner MD DEGREE						ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED 8/29/81		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jay Weiner MD						22e. ADDRESS 50 W Edmonston Dr Rockville, MD 20851					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 9/1/81		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery S.S.			23d. LOCATION CITY OR TOWN COUNTY STATE Mont. Maryland			
24. FUNERAL DIRECTOR NAME Hines/Rinaldi F.H. 11800 N.H. Ave. S.S.Md.						25. DATE REC'D. BY REGISTRAR SEP 3 1981			26. REGISTRAR'S SIGNATURE Theresa J. Martin		

1. The first part of the report is a general description of the project and its objectives. This section is followed by a detailed description of the methodology used in the study. The results of the study are then presented in a series of tables and figures. Finally, the conclusions of the study are discussed, along with some suggestions for further research.

2. The second part of the report is a detailed description of the methodology used in the study. This section is followed by a detailed description of the results of the study. The results are presented in a series of tables and figures. Finally, the conclusions of the study are discussed, along with some suggestions for further research.

3. The third part of the report is a detailed description of the results of the study. The results are presented in a series of tables and figures. Finally, the conclusions of the study are discussed, along with some suggestions for further research.

4. The fourth part of the report is a detailed description of the conclusions of the study. The conclusions are discussed, along with some suggestions for further research.

5. The fifth part of the report is a detailed description of some suggestions for further research. This section is followed by a detailed description of the conclusions of the study. The conclusions are discussed, along with some suggestions for further research.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medicolegal examination must be notified at once.

DHMH - 16 50M 1/81
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 2 1 7 7 1

1 - FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) JOSEPH J. PETERS			2a. DATE OF DEATH MONTH DAY YEAR August 29 1981			2b. HOUR 11:40 A.M.				
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR August 24 1906		6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Conn.		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.				
10. CITY OR TOWN OF DEATH Chevy Chase		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 5100 Dorset Ave.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. C. P. A.		12b. KIND OF BUSINESS OR INDUSTRY Accounting		
13a. STATE Md.			13b. COUNTY Montgomery		13c. CITY OR TOWN Chevy Chase		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 5100 Dorset Ave.	
14. FATHER'S NAME FIRST MIDDLE LAST Steven Peters				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Frances Gladesewski						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 116-01-2404		17. INFORMANT ADDRESS 8712 Preston Place Rosemarie N. Lavins Chevy Chase, Md. 20815					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) carcinoma of the lung 1629 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 yr.		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 10										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) (this hospital) attended the deceased from July 19 81 to 8-29 81 , that (2) (we) lost 10 saw the deceased alive on 8-17 81 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If well and did not view the body after death.)										
22b. SIGNATURE James Brodsky						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8-29-81		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) James Brodsky MD					22e. ADDRESS 4701 Willard Ave Chevy Chase Md. 20815					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 8/31/81		23c. NAME OF CEMETERY OR CREMATORY Natl. Memorial Park		23d. LOCATION CITY OR TOWN COUNTY STATE Falls Church Va.			
24. FUNERAL DIRECTOR NAME Joseph Gawler's Sons			5130 Wisc. Ave. N. W. Wash., D. C. 20016			25a. DATE REC'D. BY REGISTRAR SEP 1 1981		25b. REGISTRAR'S SIGNATURE Charles Jan Nether		

MEDICAL CERTIFICATION

9 9

5 500
BP



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05/01/20

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 2 1 7 7 2

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) MARY HELEN PICKENS			2a. DATE OF DEATH MONTH 08 DAY 21 YEAR 81			2b. HOUR 12 AM PM	
3 SEX FEMALE		4 RACE WHITE		5. DATE OF BIRTH MONTH 10 DAY 24 YEAR 01		6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash DC		7b. CITIZEN OF WHAT COUNTRY? U.S.A		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Mont. MD.	
10. CITY OR TOWN OF DEATH Chevy Chase		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bethesda Nursing Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOA MAKER		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MD.		13b. COUNTY MONT		13c. CITY OR TOWN SILVER SPRING		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST WILLIAM MIDDLE R. LAST STORAY		15. MOTHER'S MAIDEN NAME FIRST MARY MIDDLE E. LAST WHITE		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 577-10-8414	
17. INFORMANT REBECCA F. ROGERS		18. ADDRESS 1119 KIRKLYNN AVE T.P. MD		19. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	

11. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) congestive heart failure		5 yrs	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ASHD		10 yrs	
DUE TO, OR AS A CONSEQUENCE OF (c)			

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M.		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			

22a. I certify that (I) (this hospital) attended the deceased from **8-19-81** to **8-21-81**, that (I) (the) lost saw the deceased alive on **8-19-81**, and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (did) (did not) view the body after death

22b. SIGNATURE George Sengstack		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8-21-81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) GEORGE SENGSTACK M.D.		22e. ADDRESS 9241 COLUMBIA BLVD. SILVER SPRING MD					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Aug. 24, 1981		23c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery		23d. LOCATION CITY OR TOWN Washington COUNTY MD STATE DC	
24. FUNERAL DIRECTOR NAME Takona Funeral Home ADDRESS 254 Conwell St. NW		25. DATE REC'D BY REGISTRAR Aug 25 1981 REGISTRAR'S SIGNATURE [Signature]					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified before burial or cremation.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8 1 2 1 7 7 3	
1- FOR STATE REGISTRAR										CERTIFICATE OF DEATH	
1 DECEASED NAME (TYPE OR PRINT)										2a DATE OF DEATH	
2b HOUR										2c MONTH DAY YEAR	
3 SEX										4 RACE	
5 DATE OF BIRTH										6 AGE (IN YEARS LAST BIRTHDAY)	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)										7b CITIZEN OF WHAT COUNTRY?	
8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										9 BALTIMORE CITY OR COUNTY OF DEATH	
10 CITY OR TOWN OF DEATH										11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	
12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)										12b KIND OF BUSINESS OR INDUSTRY	
13a STATE										13b COUNTY	
13c CITY OR TOWN										13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME										15 MOTHER'S MAIDEN NAME	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)										16b SOCIAL SECURITY NO.	
17 INFORMANT										ADDRESS	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY:										IMMEDIATE CAUSE (a)	
4292										ARRHYTHMIA, CARDIAC	
DUE TO, OR AS A CONSEQUENCE OF										12 hrs	
CONGESTIVE HEART FAILURE										1 week	
DUE TO, OR AS A CONSEQUENCE OF										SENILE AGITATION	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:										ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE	
19a DATE OF OPERATION										19b CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a AUTOPSY?										20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										21b TIME OF INJURY	
21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)										21d INJURY OCCURRED	
21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)										21f LOCATION	
22a I certify that (I) (this hospital) attended the deceased from										22b SIGNATURE	
22c DATE SIGNED										22d PHYSICIAN'S NAME (TYPE OR PRINT)	
22e ADDRESS										22f DATE REC'D. BY REGISTRAR	
22g REGISTRAR'S SIGNATURE										22h REGISTRAR'S NAME	
23a BURIAL, CREMATION, REMOVAL (SPECIFY)										23b DATE	
23c NAME OF CEMETERY OR CREMATORY										23d LOCATION	
24 FUNERAL DIRECTOR										25a DATE REC'D. BY REGISTRAR	
25b REGISTRAR'S SIGNATURE										25c REGISTRAR'S NAME	
John HENRY Poetzman JR.										8-22-81	
MALE CAUCASIAN										4:10 PM	
11-10-02										78 YRS.	
WASHINGTON, D.C. U.S.A.										Montgomery MD.	
Silver Spring Holy Cross Hospital										ELECTRICIAN	
MARYLAND PRI. GEORGES ADELPHI										9203 26TH AVENUE	
JOHN HENRY POETZMAN, SR.										ANN HUGHES	
NO										578-05-8353	
MARGARET C. POETZMAN										SAME AS 13 WIFE	
4292										ARRHYTHMIA, CARDIAC	
DUE TO, OR AS A CONSEQUENCE OF										12 hrs	
CONGESTIVE HEART FAILURE										1 week	
DUE TO, OR AS A CONSEQUENCE OF										SENILE AGITATION	
ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE											
FEB 10 19 79										AUG 22 19 81	
HUBERT J. ALPERT, M.D.										AUG 22, 1981	
HUBERT J. ALPERT, M.D.										8030 FENTON ST. SILVER SPRING, MD. 20910	
BURIAL										8/25/81	
GATE OF HEAVEN										SILVER SPRING MONT MD.	
FRANCIS J. COLLINS										AUG 25 1981	
500 UNIV. BLVD., W., SILVER SPRING, MD. 20901										Name Jan Martin	

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			MONTH			DAY			YEAR			2b. HOUR		
Mary Maddra Powell			8			5			81			10:45 PM					
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR			8. IF UNDER 24 HRS.		
Female			white			MONTH DAY YEAR 4 25 07			74 YRS.			MONTHS DAYS HOURS MIN.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH								
VA			U.S.A.						Montgomery.								
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY								
Takoma Park			Washington Adventist Hospital			Housewife											
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS					
Maryland.			Montg.			Silver Spring			YES <input type="checkbox"/> NO <input type="checkbox"/>			843 Northampton Dr. S. S.					
14. FATHER'S NAME (FIRST MIDDLE LAST)			15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST)														
Jarvis			Madora			Welmore.											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT			ADDRESS								
No.			578-18-9465			Robert T. Powell.			13 e.								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>INTRAPLEURAL HEMORRHAGE</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) <u>CONTUSION OF CHEST</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 HOURS			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>SEIZURE DISORDER - URINARY TRACT INFECTION</u>																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?								
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR (A.M. OR P.M.) MONTH DAY YEAR 4 ³⁰ P.M. Aug 5 1981			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)											
			Fell - NOT WITNESSED														
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION CITY OR TOWN COUNTY STATE											
			MANOR CARE NURSING HOME			METZGER RD Hyattsville PG, Md.											
22a. I certify that (I) (this hospital) attended the deceased from <u>Nov</u> 19 <u>69</u> to <u>Aug 5</u> 19 <u>81</u> , that (I) (we) lost saw the deceased alive on <u>Aug 5</u> 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE			DEGREE			ATTENDING MEDICAL STAFF PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED								
Robert B. Irey			MD						Aug 6, 1981								
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS														
ROBERT B. IREY			1461 New Hampshire Ave Silver Spring														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION CITY OR TOWN COUNTY STATE								
Burial			Aug. 7, 1981			George Washington Riggs Rd. P. Geo. Md.											
Takoma Funeral Home.																	
25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE														
AUG 10 1981			James J. Norton														

Examiner.

Medical.

Approved by, Dr. John Rodgers.

MEDICAL CERTIFICATION

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages should be detached for use as the burial/transit permit. Then please remove corban papers. Pages 1 and 2 should be filed within 72 hours after death. Page 3 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 20b is marked as item 18, hospital injury, or other traumatic event, the medical examiner must be notified at once.

BP

RELEASED BY: DR. JOHN ROGERS, DEPT. MED. EXAMINER

8/3/81

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the medical examiner, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the medical examiner, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 1 2 1 7 7 5	
1- FOR STATE REGISTRAR				CERTIFICATE OF DEATH	
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH	
FIRST MIDDLE LAST William Prescott Pringle.				MONTH DAY YEAR HOUR August 3, 1981 8 A M	
3. SEX Male.		4. RACE White.		5. DATE OF BIRTH MONTH DAY YEAR Oct. 10 1900	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maine		7b. CITIZEN OF WHAT COUNTRY? USA		6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS.	
10. CITY OR TOWN OF DEATH Takoma Park.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 209 Domer Ave. Takoma Park.		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County. MD.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY		13a. STREET ADDRESS 209 Domer Ave. Takoma Pk.	
13b. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13c. STREET ADDRESS 209 Domer Ave. Takoma Pk.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Henry N. Pringle		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Not Available		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no	
16b. SOCIAL SECURITY NO. 578-30-2868		17. INFORMANT Wm. P. Pringle (son)		17. ADDRESS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest 2 electrolyte imbalance.</u> 2765 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Malnutrition</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Dehydration.</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE		21g. DATE OF OPERATION		21h. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22a. I certify that (I) (this hospital) attended the deceased from <u>August 2, 1981</u> to <u>August 2, 1981</u> , that (I) (we) last saw the deceased alive on <u>Aug 2, 1981</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>[Signature]</u>		22c. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED <u>Aug. 4/81</u>	
22e. PHYSICIAN'S NAME (TYPE OR PRINT) SMITH HO, M.D.		22f. ADDRESS 8323 Haddon Dr. Takoma Park Md 20012		22g. DATE SIGNED <u>Aug. 4/81</u>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>CREMATION</u>		23b. DATE <u>AUG. 7. 1981</u>		23c. NAME OF CEMETERY OR CREMATORY <u>FORT LINCOLN CREMATORY</u>	
23d. LOCATION CITY OR TOWN COUNTY STATE <u>BRENTWOOD P.G. MD</u>		23e. NAME OF CEMETERY OR CREMATORY <u>Takoma Funeral Home, Inc.</u>		23f. LOCATION CITY OR TOWN COUNTY STATE <u>254 Carroll St. N. W. D. C.</u>	
23g. DATE RECEIVED BY REGISTRAR <u>AUG 10 1981</u>		23h. REGISTRAR'S SIGNATURE <u>[Signature]</u>		23i. DATE RECEIVED BY REGISTRAR <u>AUG 10 1981</u>	
23j. REGISTRAR'S SIGNATURE <u>[Signature]</u>		23k. DATE RECEIVED BY REGISTRAR <u>AUG 10 1981</u>		23l. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

March 1, 1951

William F. Brown

Oct. 10 1950

1950

1950

Monterey County

1951

1951

302 Lower St. Thomas Park, Berkeley

302 Lower St. Thomas Park, Berkeley

Married

302 Lower St. Thomas Park, Berkeley

302 Lower St. Thomas Park, Berkeley

302 Lower St. Thomas Park, Berkeley

302 Lower St. Thomas Park, Berkeley

Not valid to

Not valid to

Not valid to

(F. F. Brown) (son)

no

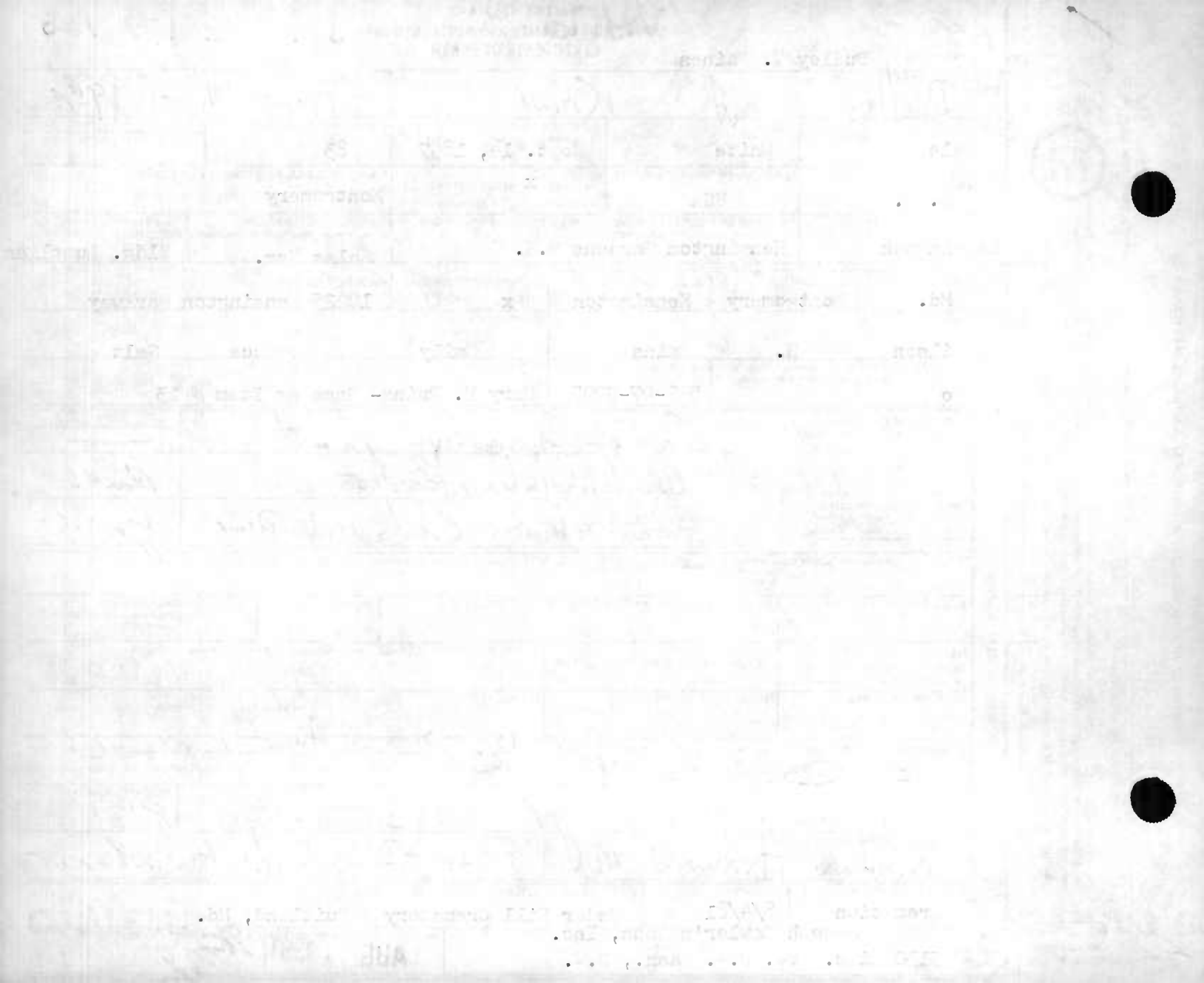
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR Dudley W. Raines		REG. NO.		8 1 2 1 7 7 6					
1. DECEASED NAME (TYPE OR PRINT) Dudley W. Rains			2. DATE OF DEATH MONTH DAY YEAR August 1, 1981			2b. HOUR 9:45 AM			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Sept. 14, 1897		6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS 1 MONTH 1 DAY	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) S. D.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH Kensington		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Kensington Gardens N.H.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Sales Mgr.		12b. KIND OF BUSINESS OR INDUSTRY Bldg. Supplies	
13a. STATE Md.		13b. COUNTY Montgomery		13c. CITY OR TOWN Kensington		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 10225 Kensington Parkway	
14. FATHER'S NAME FIRST MIDDLE LAST Wilson H. Rains			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emily Rebecca Galt			16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			
16a. SOCIAL SECURITY NO. 577-07-9907			17. INFORMANT Mary M. Rains- Same as Item # 13			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-Respiratory Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Cerebrovascular Accident DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerotic Cardiovascular Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR June 15, 1981 P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from June 15, 1981 to August 1, 1981 , that (I) (we) lost saw the deceased alive on June 15, 1981 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.									
22b. SIGNATURE Bernard A. Fennell, M.D.				DEGREE M.D.		22c. DATE SIGNED 8-1-81		22d. PHYSICIAN'S NAME (TYPE OR PRINT) Bernard A. Fennell, M.D.	
22e. ADDRESS 3720 Fairview Ave. Ken. Md 20885									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 8/4/81		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland, Md.			
24. FUNERAL DIRECTOR NAME Joseph Gawler's Sons, Inc. ADDRESS 5130 Wisc. Ave. N.W. Wash., D.C.				25a. DATE REC'D. BY REGISTRAR AUG 7 1981		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			



2541

NO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

5600 BP

150

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MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 1 2 1 7 7 7		
1. FOR STATE REGISTRAR		ARTHUR RAMO		REG. NO.		
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Arthur RAMO			2a. DATE OF DEATH MONTH DAY YEAR 8 16 81			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR June 29, 1922		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pa.		7b. CITIZEN OF WHAT COUNTRY? US		6. AGE (IN YEARS LAST BIRTHDAY) 59 YRS		
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SUBURBAN HOSPITAL		9. BALTIMORE CITY OR COUNTY OF DEATH BETHESDA Mont MD		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Vice President			12b. KIND OF BUSINESS OR INDUSTRY Publishing Co.			
13a. STATE Md.			13b. COUNTY Montgomery		13c. CITY OR TOWN Chevy Chase	
14. FATHER'S NAME FIRST MIDDLE LAST Morris Ramo			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emma Goldfarb			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. 139-16-9898		17. INFORMANT ADDRESS Helene Ramo Same as item # 13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> 1629 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Small Cell (oat cell) Carcinoma of left lung</u> (c) <u>8 months</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>4-9-</u> 19 <u>70</u> to <u>8-16-</u> 19 <u>81</u> , that (I) (we) last saw the deceased alive on <u>8-16-</u> 19 <u>81</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE Stephen W. DeJter, M.D.				22c. DATE SIGNED 8-16-81		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) STEPHEN W. DEJTER, M.D.				22e. ADDRESS 6719 WILSON LANE, BETHESDA, MD 20034		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 8/17/81		23c. NAME OF CEMETERY OR CREMATORY Crematory Cedar Hill		
23d. LOCATION CITY OR TOWN COUNTY STATE Suitland, Md.						
24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc. 5130 Wisc. Ave. N.W. Wash., D.C.				25a. DATE REC'D. BY REGISTRAR AUG 20 1981		
25b. REGISTRAR'S SIGNATURE Thom J. North						

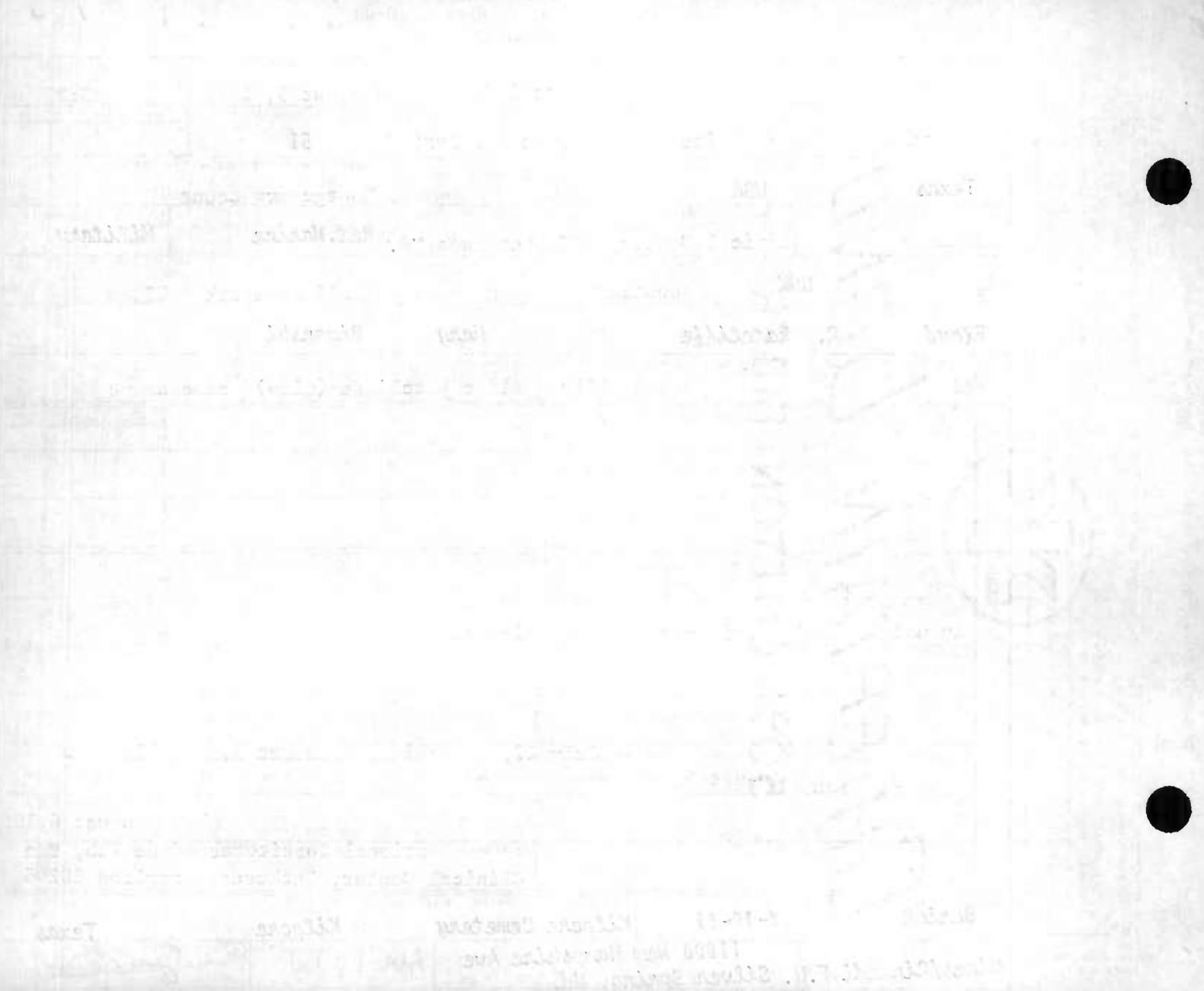
• 1901, 1902, 1903, 1904, 1905, 1906, 1907, 1908, 1909, 1910, 1911, 1912, 1913, 1914, 1915, 1916, 1917, 1918, 1919, 1920, 1921, 1922, 1923, 1924, 1925, 1926, 1927, 1928, 1929, 1930, 1931, 1932, 1933, 1934, 1935, 1936, 1937, 1938, 1939, 1940, 1941, 1942, 1943, 1944, 1945, 1946, 1947, 1948, 1949, 1950, 1951, 1952, 1953, 1954, 1955, 1956, 1957, 1958, 1959, 1960, 1961, 1962, 1963, 1964, 1965, 1966, 1967, 1968, 1969, 1970, 1971, 1972, 1973, 1974, 1975, 1976, 1977, 1978, 1979, 1980, 1981, 1982, 1983, 1984, 1985, 1986, 1987, 1988, 1989, 1990, 1991, 1992, 1993, 1994, 1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582,

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR					REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) Floyd Raymond Ratcliffe					2a. DATE OF DEATH MONTH DAY YEAR August 5, 1981					2b. HOUR 3:25 p.m.
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR August 23, 1929		6. AGE (IN YEARS LAST BIRTHDAY) 51 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN) Texas		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD				
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Clinical Center, NIH, Bethesda, Md.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. Marine		12b. KIND OF BUSINESS OR INDUSTRY Military		
13a. STATE Texas		13b. COUNTY UNK		13c. CITY OR TOWN Houston		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 11646 Sagepark 77080		
14. FATHER'S NAME FIRST MIDDLE LAST Floyd R. Ratcliffe					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Biganski					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? YES <input checked="" type="checkbox"/> NO OR UNKNOWN <input type="checkbox"/> (IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO. 452-44-2979		17. INFORMANT ADDRESS Aline Ratcliffe (wife) same as pt						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiogenic Shock 4149 DUE TO, OR AS A CONSEQUENCE OF (b) Diffuse coronary artery disease DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) intraoperative hemorrhage from left femoral artery										
19a. DATE OF OPERATION August 5, 1981		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Diffuse Coronary Disease				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from July 27, 1981 to August 5, 1981 , that <input checked="" type="checkbox"/> (we) lost the deceased alive on August 5, 1981 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, or (we) (did) (didn't) view the body after death.										
22b. SIGNATURE Anthony L. Picone		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED August 6, 1981		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Anthony L. Picone				22e. ADDRESS National Institutes of Health, The Clinical Center, Bethesda, Maryland 20205						
23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE 8-10-81		23c. NAME OF CEMETERY OR CREMATORY Kilgore Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Kilgore Texas				
24. FUNERAL DIRECTOR Hines/Rinaldi F.H. Silver Spring, Md.				25. DATE REC'D. BY REGISTRAR AUG 13 1981		REGISTRAR'S SIGNATURE James J. [Signature]				



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 2 1 7 7 9

1 - FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Charles M. Reeden			2a. DATE OF DEATH MONTH 08 DAY 1 YEAR 81		2b. HOUR 11:15 PM
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH 08 DAY 11 YEAR 06		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS.	IF UNDER 1 YEAR MONTHS DAYS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Georgia	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Wheaton	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Wheaton MANOR CARE		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Auditor	12b. KIND OF BUSINESS OR INDUSTRY U. S. Govt	
13a. STATE MD.	13b. COUNTY Montgomery	13c. CITY OR TOWN Wheaton	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 11806 Valley Road Dr	
14. FATHER'S NAME FIRST John MIDDLE unk LAST Reeden		15. MOTHER'S MAIDEN NAME FIRST Lillian MIDDLE Gravett LAST Gravett			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. 266-031232		17. INFORMANT ENNESTINE Reeden SOR 13E	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Mitastatic colon Carcinoma 1539 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) Carcinoma of colon. DUE TO, OR AS A CONSEQUENCE OF (c) 		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 yrs. Bye
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)

MEDICAL CERTIFICATION

19a. DATE OF OPERATION Spring 81	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Craniotomy - Cerebral metastases	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) (this hospital) attended the deceased from April 19 81 to July 19 81 , that (1) <input checked="" type="radio"/> saw the deceased alive on 7/20 19 81 , and that in (my) <input checked="" type="radio"/> opinion death occurred on the date and hour and from the causes stated above (1) <input checked="" type="radio"/> (we) (did) (did not) view the body after death.			
22b. SIGNATURE James R Coleman MD.		22c. DATE SIGNED 8/2/81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JAMES R COLEMAN		22e. ADDRESS 9241 COLUMBIA BLVD SILVER SPRING MD. 20910	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE Aug 4, 81	23c. NAME OF CEMETERY OR CREMATORY Arlington Hall	23d. LOCATION CITY OR TOWN Arlington COUNTY Arl STATE VA
24. FUNERAL DIRECTOR NAME W.W. Chambers		25. DATE RECEIVED BY REGISTRAR AUG 5 1981	
ADDRESS 8655 GA. Ave S.S.		REGISTRAR'S SIGNATURE [Signature]	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained by the funeral director, page 3 with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 1 21 / 80	
1. FOR STATE REGISTRAR				CERTIFICATE OF DEATH	
I. DECEASED NAME (TYPE OR PRINT)				2b. DATE OF DEATH	
Mabel L. B.				8 8 81 6:30 P.M.	
3. SEX FEMALE		4. RACE White		5. DATE OF BIRTH 7 14 89	
7a. BIRTHPLACE New York		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		6. AGE (IN YEARS LAST BIRTHDAY) 92 YRS	
10. CITY OR TOWN OF DEATH Kensington		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Circle Manor Nursing Home		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. School Teacher		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville	
14. FATHER'S NAME John		15. MOTHER'S MAIDEN NAME Ida Benjamin		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) None		17. INFORMANT Elizabeth Abell	
				ADDRESS Rockville, Maryland 4303 Judith St.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 5860 } DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) Renal Failure (c) } DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 72 Hours.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 16c.					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) (this hospital) attended the deceased from 19 75 to 8-8-81, that (we) lost saw the deceased alive on August 1, 19 81, and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Benjamin H. H. M.D.		DEGREE M.D.		22c. DATE SIGNED 8/8/81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Benjamin H. H. M.D.		22e. ADDRESS 3720 Farnsworth Ave. bet. Md. 207.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) DONATION		23b. DATE 8/8/81		23c. NAME OF CEMETERY OR CREMATORY GEO. WASH. MED. SCHOOL WASHINGTON, D.C.	
24. FUNERAL DIRECTOR NAME Columbia Mortuary Services Washington, D.C.		25. ADDRESS 225 MISSOURI AVE. N.W.		26. REC'D. BY REGISTRAR AUG 19 1981	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
1 - STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) DONALD LEONARD ROBIN			20. DATE OF DEATH MONTH DAY YEAR 8 29 81			2b. HOUR 3:45 PM		
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH DECEMBER 18, 1927		6. AGE (IN YEARS LAST BIRTHDAY) 53 YRS		
7a. BIRTHPLACE (STATE OR FOREIGN) NEW YORK		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery Co. MD.		
10. CITY OR TOWN OF DEATH SILVER SPRING		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital				12a. USUAL OCCUPATION (TYPE AND PERCENT OF WORKING LIFE) SYSTEMS ANALYST		
12b. KIND OF BUSINESS OR INDUSTRY GOVERNMENT		13a. STATE MARYLAND		13b. COUNTY PR. GEORGES		13c. CITY OR TOWN ADELPHI		
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1929 MERRIMAC DRIVE		14. FATHER'S NAME ABRAHAM		15. MOTHER'S MAIDEN NAME DORA TEPLITSKY		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE BRANCH OR SERVICE) YES WW II-NAVY		16b. SOCIAL SECURITY NO. 103-20-0995		17. INFORMANT DOLORES ROBIN, 1929 MERRIMAC DRIVE, ADELPHI, MARYLAND 20783				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MALIGNANT MELANOMA OF SKIN DUE TO, OR AS A CONSEQUENCE OF (b) RECENT LIQUOR ABUSE TO BRAIN, CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. (c) LIVER, LUNG, & LYMPH NODES APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 yrs 2 MONTHS								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 8/29 81 to 8/29 81, that (I) (we) lost saw the deceased alive on 8/29 81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.								
22b. SIGNATURE David Goldenberger				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8/30/81		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DAVID GOLDENBERGER MD				22e. ADDRESS 9801 GEORGETOWN AVE SILVER SPRING MARYLAND 20902				
23a. BURIAL, CREMATION, REMOVAL (TYPE)		23b. DATE 8/31/1981		23c. NAME OF CEMETERY OR CREMATORY MOUNT LEBANON CEMETERY		23d. LOCATION ADELPHI, PR. GEO. MARYLAND		
24. FUNERAL HOME DONALD L. STEIN HEBREW MEMORIAL FUNERAL HOME 232 CARROLL STREET, N. W., WASHINGTON, D. C.				25. DATE REC'D. BY REGISTRAR SEP 2 1981				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1 - FOR STATE REGISTRAR		REG. NO. 81 21782							
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST KENN ROGERS					2a. DATE OF DEATH MONTH DAY YEAR August 29 '81		2b. HOUR MIN. 0735		
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR April 27, 1912		6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Austria		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bel Pre Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Professor (Ret) College		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE D.C. 13b. COUNTY --- 13c. CITY OR TOWN Washington 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					13e. STREET ADDRESS 4201 Cathedral Ave/ N.W.				
14. FATHER'S NAME FIRST MIDDLE LAST Al Rogers					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Helen Jeral				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 135-16-6728		17. INFORMANT ADDRESS Washington, D.C. Judith A. Rogers; 4201 Cathedral Ave. NW					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH CAUSED BY: IMMEDIATE CAUSE (a) Heart + respiratory arrest 4140 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio-sclerotic heart disease DUE TO, OR AS A CONSEQUENCE OF (c) 20 yrs									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hour
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Organic Brain Syn. from									
19a. DATE OF OPERATION May 19 78		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED 29409			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE May 19 78 29409 81					
22a. I certify that (I) (his hospital) attended the deceased from May 19 78 to 29409 81 , that we (we) last saw the deceased alive on 13409 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Morton Louis White M.D.				DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 2940981	
22d. PHYSICIAN'S SIGNATURE (TYPE OR PRINT) Morton Louis White M.D.				22e. ADDRESS 9911 Georgia Ave Silver Spring Md					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8-30-81		23c. NAME OF CEMETERY OR CREMATORY Judean Mem. Gardens		23d. LOCATION CITY OR TOWN COUNTY STATE Olney, Montgomery, Md.			
24. FUNERAL DIRECTOR NAME Danzansky-Goldberg Chapels; 1170 Rockville Pike									

BP

Handwritten notes in the right margin, possibly a list or index.

Main body of the document containing multiple paragraphs of handwritten text, mostly illegible due to fading and bleed-through.

LAST

ROSNER

1. M

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12b. KIND OF BUSINESS
OR INDUSTRY
JEWELRY

13e. STREET ADDRESS
11213 COLUMBIA PIKE

LAST
LITOFF

ADDRESS Burtonsville, MD
3907 Blackburn Road

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
1	1-2
2	3-4
3	5-6
4	7-8
5	9-10
6	11-12
7	13-14
8	15-16
9	17-18
10	19-20
11	21-22
12	23-24
13	25-26
14	27-28
15	29-30
16	31-32
17	33-34
18	35-36
19	37-38
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22	43-44
23	45-46
24	47-48
25	49-50
26	51-52
27	53-54
28	55-56
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30	59-60
31	61-62
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34	67-68
35	69-70
36	71-72
37	73-74
38	75-76
39	77-78
40	79-80
41	81-82
42	83-84
43	85-86
44	87-88
45	89-90
46	91-92
47	93-94
48	95-96
49	97-98
50	99-100

20. AUTOPSY?

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
self/ingested

211. LOCATION
11213 Columbia Pike Silver Springs, Md.

DATE SIGNED 8-24-81

ADDRESS 111 Penn Street

STATE

VA.

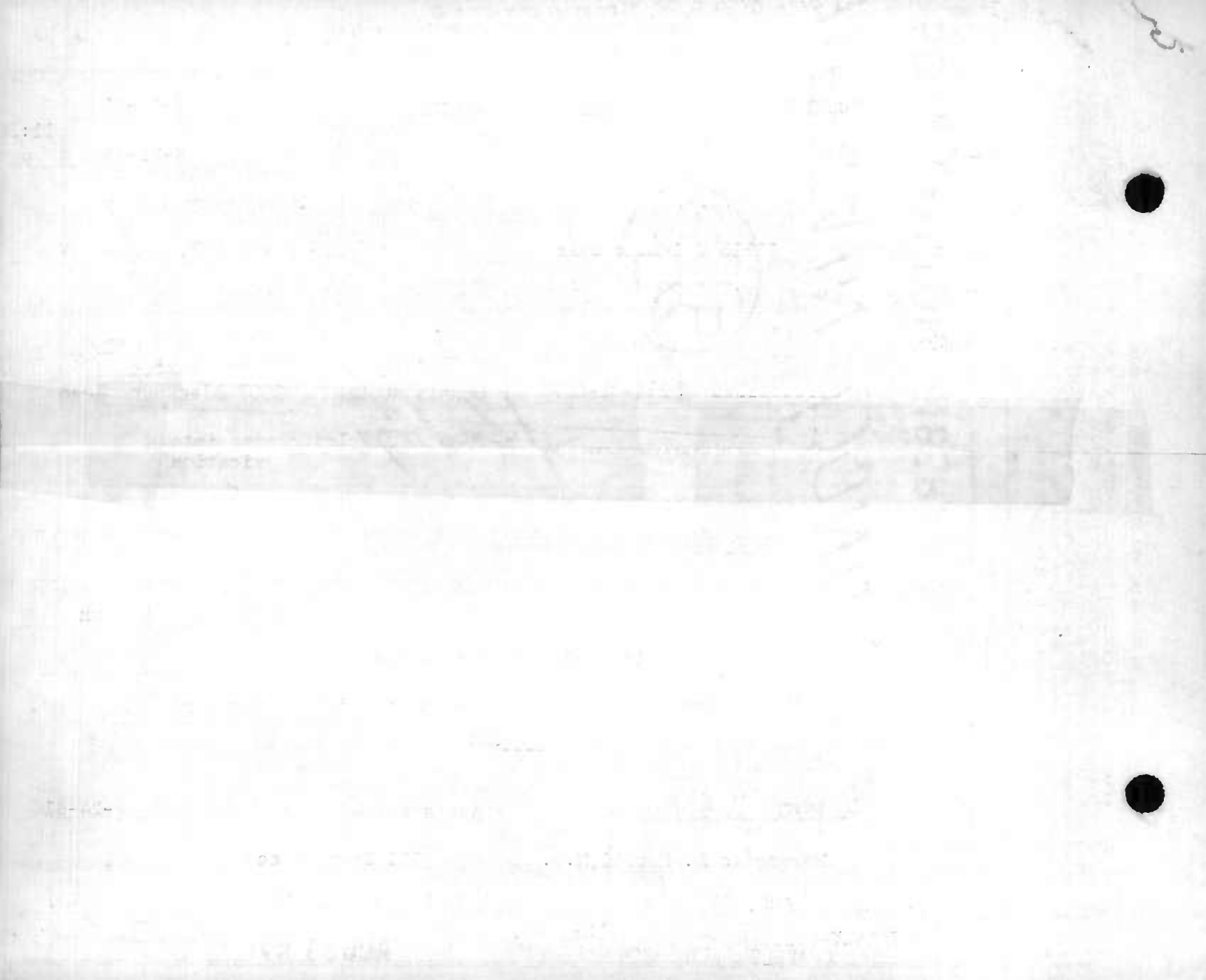
25b. REGISTRAR'S SIGNATURE

REGISTRAR'S SIGNATURE *Arne Jan Næstved*

DIVISION OF VITAL RECORDS, 201 W. PRESIDENT ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 1 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN EM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSFERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITH IN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 21784	
1- FOR STATE REGISTRAR										2a. DATE KNOWN OF DEATH	
1. DECEASED NAME (TYPE OR PRINT) Bettie Jay Rothenbuhler										2b. HOUR 4:18AM	
3. SEX F		4. RACE W		5. DATE OF BIRTH (MONTH DAY YEAR) July 19 1962		6. AGE (IN YEARS LAST BIRTHDAY) 62 YRS.		7c. DATE PRONOUNCED DEAD 8-27-81		7d. HOUR 4:18AM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) OHIO				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Mont.	
10. CITY OR TOWN OF DEATH Towson Park				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION Washington Adventist Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY U.S. GOVT.	
13a. STATE MD 13b. COUNTY Mont. 13c. CITY OR TOWN Silver Spg. 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 13e. STREET ADDRESS 9100 Wise Ave											
14. FATHER'S NAME FIRST WADE MIDDLE JAY LAST CLARK						15. MOTHER'S MAIDEN NAME FIRST GEORGIA MIDDLE CLARK LAST CLARK					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 270-18-8849				17. INFORMANT ADDRESS ERVIN F. ROTHENBUHLER SAME AS 13 HUSBAND			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF (b) Chronic Myocardial Disease DUE TO, OR AS A CONSEQUENCE OF (c) 4291 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). None											
19a. DATE OF OPERATION None				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion	
ACTUAL SIGNATURE John S. Rogers				TITLE (SPECIFY) M.D.				DATE Aug 27, 1981			
EXAMINER'S NAME (TYPE OR PRINT) JOHN S. ROGERS				ADDRESS 1919 SEMINARY ROAD, SILVER SPRING, MD.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL				23b. DATE 8/31/81		23c. NAME OF CEMETERY OR CREMATORY PARKLAWN CEMETERY				23d. LOCATION CITY OR TOWN COUNTY STATE ROCKVILLE MONT. MD.	
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS						25a. DATE REC'D. BY REGISTRAR SEP 2 1981					
ADDRESS 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901						25b. REGISTRAR'S SIGNATURE Francis J. Collins					

1961-12-21 4:10 PM

Technician

Jan

Police

1961-12-21 4:10 PM

Cont.

Washington Adventist Hospital

1961-12-21 4:10 PM

John W. [Signature]

1961-12-21 4:10 PM

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 2 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 21785	
1. DECEASED NAME (TYPE OR PRINT) Margaret C. Rush						2a. DATE KNOWN ESTIMATED 8-12-81		2b. HOUR P			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR July 10, 1916		6. AGE (IN YEARS) LAST BIRTHDAY YRS. 65		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD Aug 12 1981	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington D.C.			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.		
10. CITY OR TOWN OF DEATH Kensington			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4216 Colchester Dr.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Administrative			12b. KIND OF BUSINESS OR INDUSTRY Dental Clinic	
13a. STATE Maryland			13b. COUNTY Montgomery		13c. CITY OR TOWN Kensington		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 4216 Colchester Dr.		
14. FATHER'S NAME FIRST MIDDLE LAST George Cunningham						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Delia Divany					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. Unk.			17. INFORMANT ADDRESS Mary Delia Rush 4216 Colchester Dr.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Insufficiency Acute DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. 4110 (b) Coronary Vascular Disease DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a.											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE John D. Ball				M.D. Deputy				MEDICAL EXAMINER		DATE SIGNED Aug 12, 1981	
EXAMINER'S NAME (TYPE OR PRINT) JOHN BALL M.D.				ADDRESS 7936 Old Coopers Town Rd BETH, MD							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Aug. 17, 1981		23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Washington D.C.			
24. FUNERAL DIRECTOR NAME DeVol Funeral Home ADDRESS 2222 Wiscon. Ave. N.W. Wash.						25a. DATE REC'D. BY REGISTRAR AUG 20 1981		25b. REGISTRAR'S SIGNATURE James J. [Signature]			

